

National Aged Care Mandatory Quality Indicator Program (QI Program) Manual 4.0 Part A



National Aged Care Mandatory Quality Indicator Program Manual 4.0-Part A

This publication is published by the Australian Government Department of Health and Aged Care as a manual to administer the National Aged Care Mandatory Quality Indicator Program (QI Program).

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The information in this manual does not constitute, and must not be relied upon as, medical or clinical advice. Any medical questions must be referred to, and obtained from, an independent medical or clinical adviser.

Assistance

For further assistance, please contact the My Aged Care provider and assessor helpline on 1800 836 799. The helpline will be available between 8am and 8pm Monday to Friday, and between 10am and 2pm on Saturday local time across Australia, except for public holidays.

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1 Introduction to the National Aged Care Mandatory Quality Indicator Program

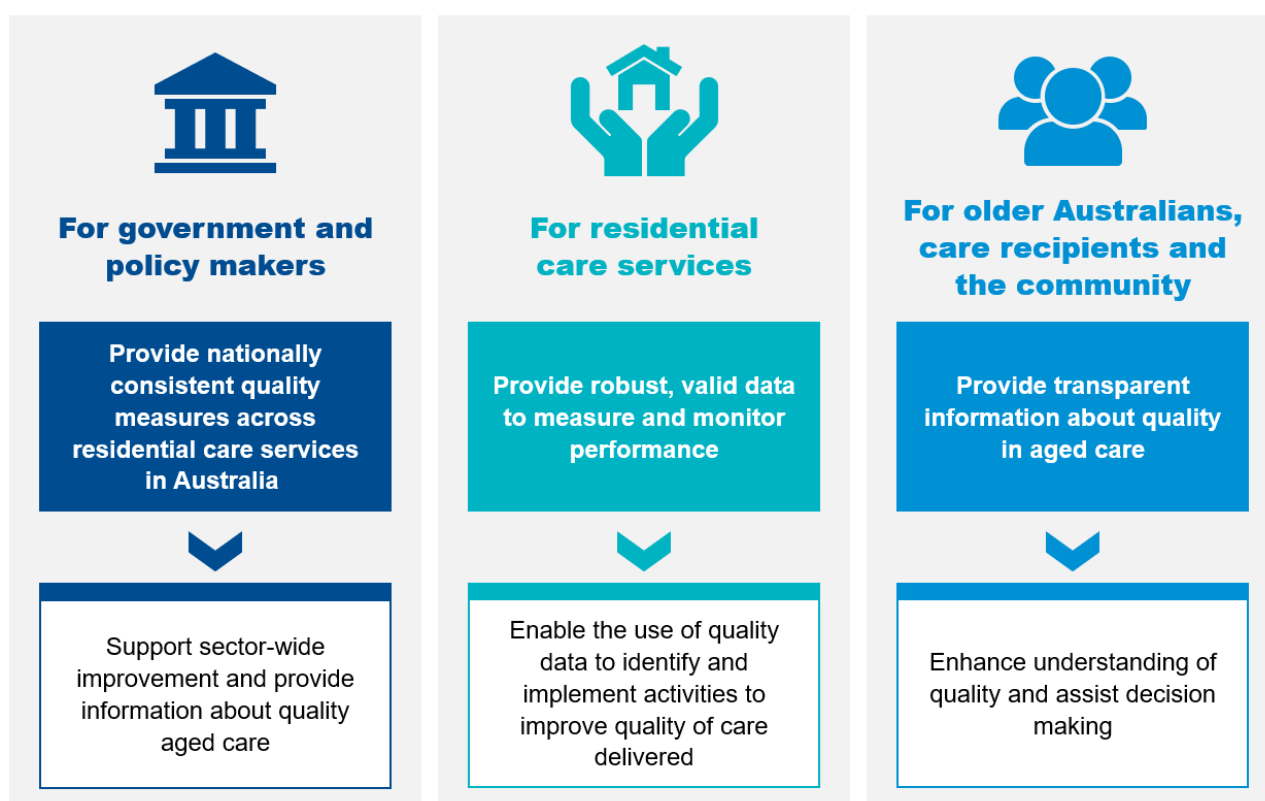
Participation in the National Aged Care Mandatory Quality Indicator Program (QI Program) has been a requirement for all approved providers of residential care services since 1 July 2019. The QI Program requires quarterly reporting against eleven quality indicators across crucial care areas — pressure injuries, restrictive practices, unplanned weight loss, falls and major injury, medication management, activities of daily living, incontinence care, hospitalisation, workforce, consumer experience, quality of life, enrolled nursing, allied health and lifestyle officer.

1.1 QI Program objectives

The objectives of the QI Program are:

- for providers to have robust, valid data to measure and monitor their performance and support continuous quality improvement in the care they provide to aged care recipients
- to give older Australians, care recipients and the community transparent information about quality in aged care to assist decision making; and
- for government to have system-level measures of quality in aged care and an evidence base to inform policy and regulation.

FIGURE 1: SUMMARY OF QI PROGRAM OBJECTIVES



2 Quality indicators in the QI Program

The QI Program requires the collection and reporting of quality indicators that relate to important aspects of quality of care across 14 crucial care areas. Data for each quality indicator is collected through measurements and assessments within each of the categories set out in Figure 2. Information is then compiled, derived and is provided to the Secretary of the Australian Government Department of Health and Aged Care (Secretary), or the Secretary's delegate, in accordance with the [Aged Care Act 1997](#) (Aged Care Act).

Pursuant to Part 4A of the [Accountability Principles](#), an approved provider must, for each quarter of a financial year, give the Secretary a report (a quarterly financial report) for the approved provider for the quarter.

The Aged Care Quality and Safety Commission (Commission) is responsible for QI Program compliance. QI Program data reported by approved providers of residential care services, is used to guide the Commission's regulatory activities. The Commission's [Compliance and Enforcement Policy](#) details the approach to non-reporting of information.

All approved providers of residential care services must collect data across the 14 quality indicators, in accordance with Figure 2.

FIGURE 2: SUMMARY OF QI PROGRAM QUALITY INDICATORS

<p>QI Program quality indicators</p>	 <p>Pressure injuries</p> <ul style="list-style-type: none"> Percentage of care recipients with one or more pressure injuries Percentage of care recipients with pressure injuries, reported against 6 pressure injury stages 	 <p>Restrictive practices</p> <ul style="list-style-type: none"> Percentage of care recipients who were subject to the use of a restrictive practice Percentage of care recipients who were subject to the use of a restrictive practice exclusively through a secure area 	 <p>Enrolled nursing</p> <ul style="list-style-type: none"> Proportion of EN care minutes Proportion of nursing care minutes
 <p>Unplanned weight loss</p> <ul style="list-style-type: none"> Percentage of care recipients who experienced significant unplanned weight loss (5% or more) Percentage of care recipients who experienced consecutive unplanned weight loss 	 <p>Falls and major injury</p> <ul style="list-style-type: none"> Percentage of care recipients who experienced one or more falls Percentage of care recipients who experienced one or more falls resulting in major injury 	 <p>Medication management</p> <ul style="list-style-type: none"> Percentage of care recipients who were prescribed nine or more medications Percentage of care recipients who received antipsychotic medications 	 <p>Allied health</p> <ul style="list-style-type: none"> Allied health care minutes Percentage of recommended allied health services received
 <p>Activities of daily living</p> <ul style="list-style-type: none"> Percentage of care recipients who experienced a decline in activities of daily living 	 <p>Incontinence care</p> <ul style="list-style-type: none"> Percentage of care recipients who experienced incontinence associated dermatitis 	 <p>Hospitalisation</p> <ul style="list-style-type: none"> Percentage of care recipients who had one or more emergency department presentations Percentage of care recipients who had one or more emergency presentations or hospital admissions 	 <p>Lifestyle officer</p> <ul style="list-style-type: none"> Lifestyle officer care minutes
 <p>Workforce</p> <ul style="list-style-type: none"> Percentage of staff turnover 	 <p>Consumer experience</p> <ul style="list-style-type: none"> Percentage of care recipients who report 'good' or 'excellent' experience of the service 	 <p>Quality of life</p> <ul style="list-style-type: none"> Percentage of care recipients who report 'good' or 'excellent' quality of life 	<p>QI Program quality indicators</p>

2.1 Value for quality indicators

For each of the quality indicators, excluding the workforce, enrolled nursing, allied health and lifestyle officer quality indicators, the percentage value is derived using the following formula:

$$\text{QI percentage value} = \frac{\text{The total number of care recipients meeting the criteria to be counted (affirmative) for the quality indicator}}{\text{The total number of care recipients assessed at the service (who do not meet exclusion criteria for the quality indicator)}} \times 100$$

For the workforce quality indicator, the percentage value is derived using the following formula:

$$\text{QI percentage value} = \frac{\text{The total number of staff meeting the criteria to be counted (affirmative) for the quality indicator}}{\text{The total number of staff at the service who were employed at the start of the quarter}} \times 100$$

For the recommended allied health services received data point of the allied health quality indicator, the percentage value is derived using the following formula:

$$\text{QI percentage value} = \frac{\text{Total number of recommended allied health services received.}}{\text{Total number of recommended allied health services}} \times 100$$

For the enrolled nursing quality indicator, the percentage value is derived using the following formulas:

$$\text{QI percentage value} = \frac{\text{EN care minutes}}{\text{EN+RN+PCW/AIN care minutes}} \times 100$$

$$\text{QI percentage value} = \frac{\text{EN+RN care minutes}}{\text{EN+RN+PCW/AIN care minutes}} \times 100$$

For allied health and lifestyle officer care minutes data points, the proportion values are derived using the following formulas:

$$\text{QI value} = \frac{\text{Allied health employee labour hours *60 + allied health agency labour hours*60}}{\text{Occupied bed days}}$$

Further information on deriving quality indicator values is in the QI Program Quick Reference Guides.

2.2 How information for the QI Program will be collected and managed

The QI Program involves specific methods for collecting, recording, submitting, and interpreting information about the quality indicators. In accordance with the Aged Care Act, residential care services must collect data consistently using the methods prescribed in the *National Aged Care Mandatory Quality Indicator Program Manual 4.0–Part A* (Manual).

Residential care services must record and submit their quality indicator data for pressure injuries, restrictive practices, unplanned weight loss, falls and major injury, medication management, activities of daily living, incontinence care, hospitalisation, workforce, consumer experience, quality of life and the allied health recommended services received data point no later than the **21st day of the month after the end of each quarter** into the Government Provider Management System (GPMS). Further information on QI data submission is outlined in sections 8 to 25 of this Manual.

The department will extract data submitted through the Quarterly Financial Report (QFR) and undertake calculations to populate the enrolled nursing, lifestyle officer and allied health care minutes data points. Please see the [QFR webpage](#) for more information on the QFR requirements. As QFR and QI reporting timeframes do not align, there may be a delay in QFR data extraction into the Quality Indicators application in GPMS.

GPMS establishes a modern system to give aged care providers, government, and older Australians access to up-to-date information on the quality and safety of aged care services. The GPMS Quality Indicators application supports submission of quarterly data as required by the National Aged Care Mandatory Quality Indicator Program (QI Program).

GPMS will:

- Allow aged care providers to self-manage, view, and maintain their records with the government
- Support provider reporting requirements
- Improve information sharing between the aged care and healthcare systems to deliver the right care the first time
- Provide the functionality to submit data using a bulk upload function to make the reporting process streamlined, allowing data for multiple services to be consolidated and uploaded simultaneously.

Further guidance relating to GPMS is in the GPMS User Guide: Quality Indicators application.

3 Quality indicator data submission

Pursuant to section 26 of the [Accountability Principles 2014](#) (Accountability Principles), approved providers must collect data for quality indicators and enter it via GPMS in order to make the information available to the Secretary, unless otherwise agreed by the Australian Government Department of Health and Aged Care (department) (for example, if another organisation is being engaged to do so). The quality indicator data must be collected every quarter (three months) based on the financial year calendar.

Pursuant to Part 4A of the [Accountability Principles](#), an approved provider must, for each quarter of a financial year, give the Secretary a report (a quarterly financial report) for the approved provider for the quarter.

Approved providers must submit quality indicator data for pressure injuries, restrictive practices, unplanned weight loss, falls and major injury, medication management, activities of daily living, incontinence care, hospitalisation, workforce, consumer experience, quality of life and recommended allied health services received into GPMS no later than the **21st day of the month after the end of each quarter**.

The department will extract data submitted through the QFR and undertake calculations for the enrolled nursing, lifestyle officer and allied health care minutes data points. As QFR and QI reporting timeframes do not align, there may be a delay in QFR data extraction into the QI Program app in GPMS. The extracted and calculated data from the QFR will display in GPMS only once the approved provider has completed their initial QFR submission.

Further guidance relating to quality indicator data submission is available in the GPMS User Guide: Quality Indicators application.

FIGURE 3: DATES FOR SUBMISSION OF QUALITY INDICATOR DATA



QFR DUE DATE	QFR DUE DATE	QFR DUE DATE	QFR DUE DATE
4 November	14 February	5 May	4 August

4 Data recording templates

A data recording template is available for each quality indicator to automatically calculate and summarise the quality indicator data to enter and submit through the GPMS Quality Indicator application. QI Program Data Recording Templates are available on the QI Program Resources page on the Department of Health and Aged Care website. Instructions on how to use the data recording template are provided within the templates.

5 Measurement and assessment – data collection for quality indicators

Pursuant to section 26(a) of the [Accountability Principles](#), approved providers must make measurements or other assessments that are relevant to indicating the quality of residential care, exactly as described in this Manual. Information from existing data sets (e.g. incident reporting systems) must not be used where information has been collected differently to what is described in this Manual.

Pursuant to Part 4A of the [Accountability Principles](#), an approved provider must, for each quarter of a financial year, give the Secretary a report (a quarterly financial report) for the approved provider for the quarter.

6 Record keeping

For each quality indicator an approved provider must, in accordance with sections 88-1 and 88-2 of the [Aged Care Act 1997](#), keep records relating to measurements and assessments and information compiled for the purposes of section 26(a), (b) and (c) of the [Accountability Principles](#).

7 Definitions

The definitions ascribed to the terms below are intended to apply for the purposes of the QI Program only.

TABLE 1: QI PROGRAM DEFINITIONS

Term	Definition
Assessment period	The period of time where services are required to collect and record data for each quality indicator. For some quality indicators, this involves retrospective audit and for others it involves a point in time observation assessment.
Collection date	The day on which care recipient data is captured, for each quality indicator assessment period.
Exclusions	Care recipients who, on the basis of meeting stipulated criteria, are no longer eligible to be included in the total counts for each quality indicator. Consequently, exclusions are deducted from the population assessed for the quality indicator and the resulting percentage value reported.

Term	Definition
	<p>Where multiple exclusion reasons apply to any care recipient who is excluded from being assessed for a quality indicator, the primary reason should be applied and reported. Secondary reasons are not required to be reported.</p> <p>The exception to this definition is an exclusion for the incontinence care quality indicator. Care recipients who did not have incontinence, are not eligible to be included in the population assessed for incontinence associated dermatitis. However, these care recipients do continue to be included in the total count assessed for the incontinence care quality indicator.</p>



8 Pressure injuries

8.1 Overview of pressure injuries

A pressure injury is an injury of the skin and/or underlying tissue, usually over a bony prominence, caused by unrelieved pressure, friction or shearing¹. Pressure injuries are potentially life threatening, decrease the care recipient's quality of life, and are expensive to manage. Regular monitoring for pressure injuries is important because pressure injuries may develop rapidly and are a painful, costly, and often preventable complication of which many older Australians are at risk.

Approved providers of residential care services must collect and report on pressure injury data quarterly, according to the requirements set out in this Manual.

The ICD-10 Australian Modified (AM)² pressure injury classification system outlined in the *Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline 2019*³ is the pressure injury classification system used for the purposes of the QI Program.


¹ Australian Commission on Safety and Quality in Health Care (ACSQHC) (2012), *Safety and Quality Improvement Guide Standard 8: Preventing and Managing Pressure Injuries*, ACSQHC, Sydney.

² Independent Hospital and Pricing Authority (IHPA) (2019), *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM)*, IHPA.

³ European Pressure Ulcer Advisory Panel (EPUAP), National Pressure Injury Advisory Panel (NPIAP) and Pan Pacific Pressure Injury Alliance (PPPIA) (2019), *Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline. The International Guideline 2019*, Emily Haesler (Ed.), EPUAP/NPIAP/PPPIA.



TABLE 2: PRESSURE INJURIES QUALITY INDICATOR OVERVIEW

 Percentage of care recipients with pressure injuries, reported against six pressure injury stages	Collection <ul style="list-style-type: none">• A single observation assessment for each care recipient, around the same time every quarter
	Quality indicator reporting <ul style="list-style-type: none">• Care recipients with one or more pressure injuries• Care recipients with one or more pressure injuries reported against each of the six pressure injury stages:<ul style="list-style-type: none">○ Stage 1 Pressure Injury○ Stage 2 Pressure Injury○ Stage 3 Pressure Injury○ Stage 4 Pressure Injury○ Unstageable Pressure Injury○ Suspected Deep Tissue Injury
	Additional reporting <ul style="list-style-type: none">• Care recipients assessed for pressure injuries• Care recipients with one or more pressure injuries acquired outside of the service during the quarter• Care recipients with one or more pressure injuries acquired outside of the service during the quarter, reported against each of the six pressure injury stages:<ul style="list-style-type: none">○ Stage 1 Pressure Injury○ Stage 2 Pressure Injury○ Stage 3 Pressure Injury○ Stage 4 Pressure Injury○ Unstageable Pressure Injury○ Suspected Deep Tissue Injury
	Exclusions <ul style="list-style-type: none">• Care recipients who withheld consent to undergo an observation assessment for pressure injuries for the entire quarter• Care recipients who were absent from the service for the entire quarter

8.2 Key terms for pressure injuries

A **pressure injury** is an injury of the skin and/or underlying tissue, usually over a bony prominence, caused by unrelieved pressure, friction or shearing⁴.

The ICD 10 Australian Modified (AM) pressure injury classification system outlined in the *Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline 2019* includes the following six pressure injury stages:

⁴ Australian Commission on Safety and Quality in Health Care (2012), *Safety and Quality Improvement Guide Standard 8: Preventing and Managing Pressure Injuries*, Sydney.



TABLE 3: STAGES OF PRESSURE INJURIES

STAGE 1 PRESSURE INJURY

Intact skin with non-blanchable redness of a localised area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding areas. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.

STAGE 2 PRESSURE INJURY

Partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

STAGE 3 PRESSURE INJURY

Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss.

STAGE 4 PRESSURE INJURY

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunnelling. The depth of a stage 4 pressure injury varies by anatomical location.

UNSTAGEABLE PRESSURE INJURY

Full thickness skin and tissue loss in which the base of the injury is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough or eschar is removed to expose the base of the wound, the stage cannot be determined. Excludes pressure injury reclassified to stage 3 or 4 after exposure/debridement.

SUSPECTED DEEP TISSUE INJURY

Purple or maroon localised area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment. Excludes pressure injury reclassification to stage 1 to 4 after exposure/debridement.

8.3 Measurements and assessments for pressure injuries

The purpose of assessing a care recipient through the process set out below is to collect data relating to the pressure injury quality indicator.

Pursuant to section 26(a) of the [Accountability Principles](#), approved providers must make assessments and measurements that are relevant to indicating the quality of residential care in accordance with the requirements listed below.



1. Identify a date once every quarter to assess each care recipient residing at the service for pressure injuries, this assessment should be on or around the same time each quarter.
2. Inform care recipients about the proposed observation assessment and ensure consent is sought from each care recipient before the assessment can take place.

Note: This should be completed as part of the care recipient's routine personal care (e.g. bathing and toileting).

3. Record the care recipients excluded because they withheld consent to undergo an observation assessment for pressure injuries for the entire quarter.
4. Record the care recipients excluded because they were absent from the service for the entire quarter (e.g. the care recipient was hospitalised for the entire quarter).
5. Conduct a full-body observation assessment of each care recipient residing at the service during the quarter to assess for the presence of pressure injuries. Where possible, do this as part of the care recipient's usual personal care.
6. Record each care recipient with one or more pressure injuries.

Note: All instances of pressure injuries must be recorded at this Step, irrespective of where they were acquired.

7. Record each care recipient with one or more pressure injuries against each of the six stages under the ICD-10-AM (2019) pressure injury classification system:
 - Stage 1 Pressure Injury
 - Stage 2 Pressure Injury
 - Stage 3 Pressure Injury
 - Stage 4 Pressure Injury
 - Unstageable Pressure Injury
 - Suspected Deep Tissue Injury

Note: The care recipient may have more than one pressure injury. In this case all pressure injuries must be assessed and the presence of a pressure injury at each stage (one or more) must then be recorded against each of the six stages.

8. Record each care recipient with one or more pressure injuries acquired outside of the service during the quarter (e.g. acquired during a hospital stay or pressure injuries present on newly arrived care recipients).
9. Record each care recipient with one or more pressure injuries that were acquired outside of the service during the quarter (e.g. acquired during a hospital stay or pressure injuries present on newly arrived care recipients), against each of the six stages under the ICD-10-AM (2019) pressure injury classification system:
 - Stage 1 Pressure Injury
 - Stage 2 Pressure Injury
 - Stage 3 Pressure Injury
 - Stage 4 Pressure Injury
 - Unstageable Pressure Injury
 - Suspected Deep Tissue Injury



Note: The care recipient may have more than one pressure injury acquired outside the service during the quarter. In this case all pressure injuries acquired outside the service during the quarter must be assessed and the presence of a pressure injury at each stage (one or more) must then be recorded against each of the six stages.

8.3.1 Inclusions for pressure injuries

All care recipients must be assessed for pressure injuries except those listed in [8.3.2. Exclusions for pressure injuries](#).

8.3.2 Exclusions for pressure injuries

Care recipients who:

- withheld consent to undergo an observation assessment for pressure injuries for the entire quarter; or
- were absent from the service for the entire quarter;

are excluded from assessment for pressure injuries but are reported under additional reporting requirements.

8.4 Data reporting for pressure injuries

Pursuant to section 26(b) of the [Accountability Principles](#), approved providers must compile or otherwise derive information from these measurements and assessments that is relevant to indicating the quality of residential care. The information compiled or derived from the measurements and assessments must not be personal information (within the meaning of the *Privacy Act 1988*) about any of the care recipients.

Approved providers must compile or derive information in accordance with the requirements below. Approved providers must ensure that the information compiled or derived in accordance with these requirements does not contain personal information about any of the care recipients.

TABLE 4 REQUIREMENTS FOR DATA REPORTING ON PRESSURE INJURIES

1	Number of care recipients assessed for pressure injuries. Note: All care recipients must be assessed for pressure injuries except those listed in 8.3.2. Exclusions for pressure injuries.	
2	Number of care recipients excluded because they withheld consent to undergo an observation assessment for pressure injuries for the entire quarter.	
3	Number of care recipients excluded because they were absent from the service for the entire quarter.	
4	Number of care recipients with one or more pressure injuries. Note: This is the total number of care recipients with one or more pressure injuries, including those acquired outside of the service.	



5	Number of care recipients with one or more pressure injuries, reported against each of the six pressure injury stages. Note: The care recipient may have more than one pressure injury. In this case all pressure injuries must be assessed and the presence of a pressure injury at each stage (one or more) must then be recorded against each of the six stages.	
6	Number of care recipients with one or more pressure injuries acquired outside of the service during the quarter.	
7	Number of care recipients with one or more pressure injuries acquired outside of the service during the quarter, reported against each of the six pressure injury stages. Note: The care recipient may have more than one pressure injury acquired outside the service. In this case all pressure injuries acquired outside the service must be assessed and the presence of a pressure injury at each stage (one or more) must then be recorded against each of the six stages.	

8.5 How to report pressure injuries

Pursuant to section 26(c) of the [Accountability Principles](#), approved providers must submit the quality indicator data into GPMS in order to make the information available to the Secretary.

Approved providers must consult with a suitably qualified health practitioner if there is uncertainty about the presence or stage of a pressure injury.

8.6 Additional resources for pressure injuries

More information and resources related to pressure injuries are available at www.health.gov.au and in QI Program Manual 4.0-Part B.



9 Restrictive practices (formerly physical restraint)

9.1 Overview of restrictive practices

The [Quality of Care Principles 2014](#) (Quality of Care Principles), define **restrictive practices** as any practice or intervention that has the effect of restricting the rights or freedom of movement of a care recipient.

The QI Program restrictive practices quality indicator measures and reports data relating to all restrictive practices, excluding chemical restraint. This includes physical restraint, mechanical restraint, environmental restraint and seclusion, as defined in the Quality of Care Principles.


Approved providers of residential care services must collect and report on restrictive practices data quarterly, according to the requirements set out in this Manual.



The [Quality of Care Principles 2014](#) (Quality of Care Principles) set out specific requirements for the use of any restrictive practice in residential care settings.

Approved providers must satisfy requirements relating to the use of a restrictive practice in relation to a care recipient, as set out in the Quality-of-Care Principles.

TABLE 5: RESTRICTIVE PRACTICES QUALITY INDICATOR OVERVIEW

 <p>Percentage of care recipients who were subject to the use of a restrictive practice</p> <p>Percentage of care recipients who were subject to the use of a restrictive practice exclusively through the use of a secure area</p>	Collection <ul style="list-style-type: none">A single three-day record review for each care recipient on a selected collection date every quarter
	Quality indicator reporting <ul style="list-style-type: none">Care recipients who were subject to the use of a restrictive practice (excluding chemical restraint)
	Additional reporting <ul style="list-style-type: none">Care recipients assessed for restrictive practices (excluding chemical restraint)Care recipients who were subject to the use of a restrictive practice (excluding chemical restraint) exclusively through the use of a secure areaCollection date
	Exclusions <ul style="list-style-type: none">Care recipients who were absent from the service for the entire three-day assessment period



9.2 Key terms for restrictive practices

For the purposes of the QI Program, **restrictive practices** includes all forms of restrictive practice, excluding chemical restraint, as follows:

- mechanical restraint is a practice or intervention that is, or that involves, the use of a device to prevent, restrict or subdue a care recipient's movement for the primary purpose of influencing the care recipient's behaviour, but does not include the use of a device for therapeutic or non-behavioural purposes in relation to the care recipient
- physical restraint is a practice or intervention that:
 - i. is or involves, the use of physical force to prevent, restrict or subdue movement of a care recipient's body, or part of a care recipient's body, for the primary purpose of influencing the care recipient's behaviour; but
 - ii. does not include the use of a hands-on technique in a reflexive way to guide or redirect the care recipient away from potential harm or injury if it is consistent with what could reasonably be considered the exercise of care towards the care recipient.
- environmental restraint is a practice or intervention that restricts, or that involves restricting, a care recipient's free access to all parts of the care recipient's environment (including items and activities as well as common grounds outside the facility) for the primary purpose of influencing the care recipient's behaviour. Locked/coded doors (including the front door) are considered a restrictive practice if they prevent a resident from accessing a part of their environment or limit their movements. The residents' environment is taken to include the person's room, any common areas within the facility, and common grounds outside the facility. While coded doors are commonly used within facilities for the safety of residents, they are a restrictive practice if a resident cannot leave freely. If facilities provide codes to residents or staff are available to open doors when required, this would not be considered an environmental restraint. However, when a code is given to residents, but they are unable to remember it or have cognitive impairments, this is an environmental restraint.
- seclusion is a practice or intervention that is, or that involves, the solitary confinement of a care recipient in a room or a physical space at any hour of the day or night where:
 - i. voluntary exit is prevented or not facilitated; or
 - ii. it is implied that voluntary exit is not permitted; or
 - iii. for the primary purpose of influencing the care recipient's behaviour.

For the purposes of the QI Program, restraint through the use of a **secure area** includes only environmental restraint, as defined above.

All listed forms of restrictive practice, including instances the care recipient or their representative instigate or request the restrictive practice, are considered restrictive practices for the purposes of the QI Program.

9.3 Measurements and assessments for restrictive practices

The purpose of assessing a care recipient through the process set out below is to collect data relating to the restrictive practices quality indicator.



Pursuant to section 26(a) of the [Accountability Principles](#), approved providers must make assessments and measurements that are relevant to indicating the quality of residential care in accordance with the requirements listed below.

1. Identify and record a collection date (DD/MM/YYYY), which is to take place during each quarter. The date must be varied and unpredictable to staff directly involved in care. The assessment period will include the selected collection date and the two days before – this must be the same three days for all care recipients at the service.
2. Record the care recipients whose records are assessed for restrictive practices (excluding chemical restraint).
3. Record the care recipients excluded because they were absent from the service for the entire three-day assessment period (e.g. the care recipient was hospitalised for the entire three-day assessment period).
4. Review care recipient records and assess whether each care recipient was subject to the use of a restrictive practice (excluding chemical restraint) on any occasion over the three-day assessment period. This will be based on the existing records of care recipients during the three-day assessment period, noting that it is a legal requirement that services document all incidences of restrictive practices (see section 15F of the Quality of Care Principles).

Note: Restrictive practices (excluding chemical restraint) must be recorded, even if a care recipient or their representative have provided consent to the use of the restrictive practice.

5. Record whether each care recipient was subject to the use of a restrictive practice (excluding chemical restraint) (once or more and including the use of secure areas) on any occasion during the three-day assessment period.
6. Of the care recipients subject to the use of a restrictive practice (excluding chemical restraint) during the three-day assessment period recorded in Step 5 above, record whether the restrictive practice was exclusively through the use of a secure area.

Note: It may not be feasible to conduct the care recipient record audit for all care recipients on a single day. The review may be spread out over several days, however the review of care recipient records must always be as they were on the identified collection date.

9.3.1 Inclusions for restrictive practices

All care recipients must be assessed for restrictive practices except those listed in [9.3.2 Exclusions for restrictive practices](#).

9.3.2 Exclusions for restrictive practices

Care recipients who were absent from the service for the entire three-day assessment period, are excluded from assessment for restrictive practices, but are reported under additional reporting requirements.






9.4 Data reporting for restrictive practices

Pursuant to section 26(b) of the [Accountability Principles](#), approved providers must compile or otherwise derive information from these measurements and assessments that is relevant to indicating the quality of residential care. The information compiled or derived from the measurements and assessments must not be personal information (within the meaning of the *Privacy Act 1988*) about any of the care recipients.



Approved providers must compile or derive information in accordance with the requirements below. Approved providers must ensure that the information compiled or derived in accordance with these requirements does not contain personal information about any of the care recipients.

TABLE 6: REQUIREMENTS FOR DATA REPORTING ON RESTRICTIVE PRACTICES

1	The collection date for the quarter.	
2	Number of care recipients whose records were assessed for restrictive practices (excluding chemical restraint) over the three-day assessment period. Note: All care recipients must be assessed for restrictive practices except those listed in 9.3.2. Exclusions for restrictive practices.	
3	Number of care recipients excluded because they were absent from the service for the entire three-day assessment period.	
4	Number of care recipients subject to the use of a restrictive practice (excluding chemical restraint) (once or more and including through the use of secure areas) on any occasion during the three-day assessment period.	
5	Number of care recipients subject to the use of a restrictive practice (excluding chemical restraint) during the three-day assessment period exclusively through the use of a secure area.	

9.5 How to report restrictive practices

Pursuant to section 26(c) of the [Accountability Principles](#), approved providers must submit the quality indicator data into GPMS in order to make the information available to the Secretary.

9.6 Additional resources for restrictive practices

More information and resources related to restrictive practices are available at www.health.gov.au and in QI Program Manual 4.0 - Part B.



10 Unplanned weight loss - significant

Unplanned weight loss is the result of deficiency in a person's dietary intake relative to their needs and may be a symptom or consequence of disease. The unplanned weight loss quality indicator is reported against:

1. significant unplanned weight loss (this Section), and
2. consecutive unplanned weight loss (see Section 11.0 of this Manual).


Approved providers are required to collect and record data for each category.

10.1 Overview of significant unplanned weight loss

Significant unplanned weight loss is defined as weight loss equal to or greater than 5% over a three-month period. Regular monitoring for significant unplanned weight loss is important because many causes of weight loss can be addressed if detected early.

Approved providers of residential care services must collect and report on significant unplanned weight loss data quarterly, according to the requirements set out in this Manual.

Table 1: Significant unplanned weight loss quality indicator overview

 Percentage of care recipients who experienced significant unplanned weight loss (5% or more)	Collection <ul style="list-style-type: none">• The weight of each care recipient is collected in the last month (finishing weight) of the quarter and compared to their weight record in the last month of the previous quarter (previous weight) to determine percentage of weight loss
	Quality indicator reporting <ul style="list-style-type: none">• Care recipients who experienced significant unplanned weight loss (5% or more)
	Additional reporting <ul style="list-style-type: none">• Care recipients assessed for significant unplanned weight loss
	Exclusions <ul style="list-style-type: none">• Care recipients who withheld consent to be weighed• Care recipients who are receiving end-of-life care• Care recipients who did not have the required weights recorded (e.g. previous and/or finishing weight) and comments providing explanation as to why the weight recording/s are absent



10.2 Key terms for significant unplanned weight loss

For the purposes of the QI Program, **unplanned weight loss** is where there is no written strategy from a medical doctor or dietitian recommending planned weight loss for the care recipient.

Note: If a care recipient has a written record from a medical doctor or dietitian, which includes intentional weight loss (for example, body fat or fluid), this weight loss will not be counted as unplanned weight loss. This is because it does not meet the definition. Where no such record exists, all weight loss must be considered unplanned regardless of the body size or any other characteristic of the care recipient.

Significant unplanned weight loss is weight loss equal to or greater than 5% over a three-month period. Approved providers can determine this by comparing the previous weight (finishing weight from the previous quarter) and the finishing weight from the current quarter. Both weights must be available to give this result.

Previous weight is the weight recorded for each care recipient, in the final month of the previous quarter. The previous weight for significant and consecutive unplanned weight loss is the same weight measurement collected at the same time, in the final month of the previous quarter.

Finishing weight is the final weight recorded for each care recipient, recorded in the final month of the current quarter. The finishing weight for significant and consecutive unplanned weight loss is the same weight measurement collected at the same time, in the final month of the current quarter.

For the purposes of the QI Program, **end-of-life care** is the terminal phase of life. This is where death is imminent and likely to occur within three months. This is sometimes referred to as *actively dying*.

10.3 Measurements and assessments for significant unplanned weight loss

The purpose of assessing a care recipient through the process set out below is to collect data relating to the significant unplanned weight loss quality indicator.

Pursuant to section 26(a) of the [Accountability Principles](#), approved providers must make assessments and measurements that are relevant to indicating the quality of residential care in accordance with the requirements listed below.

Note: Previous weights and finishing weights may have already been recorded for each care recipient as part of assessments and measurements made for consecutive unplanned weight loss. The previous weights and finishing weights can be used for significant unplanned weight loss and do not need to be collected again.

1. Using your service's weight records, identify each care recipient's previous weight (finishing weight from the previous quarter).
2. In the final month of the current quarter, collect and record the finishing weight for each care recipient residing at the service, using a calibrated scale.

Note: Always request the consent of care recipients to assess their body weight before making the assessment. If they withhold consent to be assessed for their finishing weight, record this (see Step 3).

Note: Weigh care recipients at or around the same time each month.



Note: Weigh care recipients at around the same time of the day and wearing clothing of a similar weight (e.g. a single layer without coats or shoes).

3. Record the care recipients excluded because they withheld consent to be weighed on the finishing weight collection date.
4. Record the care recipients excluded because they are receiving end-of-life care.
5. Record the care recipients excluded because they did not have the required weights recorded (e.g. previous and/or finishing weight). Include comments as to why the weight recording/s are absent (e.g. the care recipient was hospitalised).
6. For each care recipient who provided their consent, compare their finishing weight from the current quarter with their previous weight (finishing weight from the previous quarter) and calculate the percentage of weight loss (formula provided below). The percentage of unplanned weight loss can be calculated using an automated template or the following formula:

$$\text{Percentage weight loss} = \frac{(\text{Finishing weight of current quarter} - \text{Finishing weight of previous quarter})}{\text{Finishing weight of previous quarter}} \times 100$$

Note: Care recipients who have a written strategy and/or ongoing records relating to planned weight loss are not counted as unplanned weight loss.

10.3.1 Inclusions for significant unplanned weight loss

All care recipients must be assessed for significant unplanned weight loss except those listed in [10.3.2. Exclusions for significant unplanned weight loss](#).

10.3.2 Exclusions for significant unplanned weight loss

Care recipients who:

- withhold consent to be weighed on the finishing weight collection date; or
- are receiving end-of-life care; or
- do not have the required weights recorded (e.g. previous and/or finishing weight)

are excluded from assessments for significant unplanned weight loss but are reported under additional reporting requirements.

Note: Care recipients residing at the service who did not have a previous weight recorded (finishing weight for the previous quarter), must have a finishing weight collected and recorded using a calibrated scale, in the final month of the current quarter through the process set out above.






10.4 Data reporting for significant unplanned weight loss

Pursuant to section 26(b) of the [Accountability Principles](#), approved providers must compile or otherwise derive information from these measurements and assessments the following information that is relevant to indicating the quality of residential care. The information compiled or derived from the measurements and assessments must not be personal information (within the meaning of the *Privacy Act 1988*) about any of the care recipients.



Approved providers must compile or derive information in accordance with the requirements below. Approved providers must ensure that the information compiled or derived in accordance with these requirements does not contain personal information about any of the care recipients.

Table 2: SIGNIFICANT UNPLANNED WEIGHT LOSS QUALITY INDICATOR OVERVIEW

1	Number of care recipients assessed for significant unplanned weight loss. Note: All care recipients must be assessed for significant unplanned weight loss except those listed in 10.3.2. Exclusions for significant unplanned weight loss.	
2	Number of care recipients excluded because they withheld consent to be weighed on the finishing weight collection date.	
3	Number of care recipients excluded because they are receiving end-of-life care.	
4	Number of care recipients excluded because they did not have the required weights recorded (e.g. previous and/or finishing weights). Include comments as to why the weight recording/s are absent.	
5	Number of care recipients who experienced significant unplanned weight loss of 5% or more when comparing their finishing weight and previous weight. Note: Remember care recipients who have a written strategy and/or ongoing record relating to planned weight loss are not counted as unplanned weight loss.	

10.5 How to report significant unplanned weight loss

Pursuant to section 26(c) of the [Accountability Principles](#), approved providers must submit the quality indicator data into GPMS in order to make the information available to the Secretary.

10.6 How to record information in the Government Provider Management System (GPMS)

In giving information relating to significant unplanned weight loss to the Secretary pursuant to section 26(c) of the [Accountability Principles](#), approved providers must note care recipients who were excluded because they did not have a finishing weight recorded for the current or previous quarter, including the reason why the weight recording/s are absent, in the comments section in GPMS. Approved providers must ensure that the information compiled or derived in accordance with these requirements does not contain personal information about any of the care recipients.



10.7 Additional resources for significant unplanned weight loss

More information and resources related to significant unplanned weight loss are available at www.health.gov.au and in QI Program Manual 4.0 - Part B.



IMPORTANT NOTE

All unplanned and unexpected weight loss must be investigated promptly, and appropriate treatment commenced.

If a care recipient cannot be weighed, it is still good practice to monitor them using alternative means such as mid-arm or calf circumference. This ensures changes are identified and appropriate strategies put in place.



11 Unplanned weight loss – consecutive

Unplanned weight loss is the result of deficiency in a person’s dietary intake relative to their needs and may be a symptom or consequence of disease. The unplanned weight loss quality indicator is reported against:

1. significant unplanned weight loss (see Section 10 of this Manual), and
2. consecutive unplanned weight loss (this Section).


Approved providers are required to collect and record data for each category.

11.1 Overview of consecutive unplanned weight loss

Consecutive unplanned weight loss is weight loss of any amount every month over three consecutive months of the quarter. Consecutive unplanned weight loss should not be dismissed as a natural aged-related change. The detection of consecutive unplanned weight loss may be an early indicator of a symptom or consequence of disease and can be addressed if detected early.

Approved providers of residential care services must collect and report on consecutive unplanned weight loss data quarterly, according to the requirements set out in this Manual.

Table 9: CONSECUTIVE UNPLANNED WEIGHT LOSS QUALITY INDICATOR OVERVIEW

 Percentage of care recipients who experienced consecutive unplanned weight loss	Collection <ul style="list-style-type: none">• Three monthly weights are collected for each care recipient every quarter and are compared against each other, as well as the finishing weight from the previous quarter (previous weight), to determine consecutive unplanned weight loss
	Quality indicator reporting <ul style="list-style-type: none">• Care recipients who experienced consecutive unplanned weight loss of any amount
	Additional reporting <ul style="list-style-type: none">• Care recipients assessed for consecutive unplanned weight loss
	Exclusions <ul style="list-style-type: none">• Care recipients who withheld consent to be weighed on the starting, middle and/or finishing weight collection dates• Care recipients who are receiving end-of-life care• Care recipients who did not have the required weights recorded (e.g. previous, starting, middle and/or finishing weights) and comments providing explanation as to why the weight recording/s are absent



11.2 Key terms for consecutive unplanned weight loss

For the purposes of the QI Program, **unplanned weight loss** is where there is no written strategy from a medical doctor or dietitian recommending planned weight loss for the care recipient.

Note: If a care recipient has a written record from a medical doctor or dietitian, which includes planned weight loss (e.g. body fat or fluid), this weight loss will not be counted as unplanned weight loss because it does not meet the definition. Where no such record exists, all weight loss must be considered unplanned regardless of the body size or any other characteristic of the care recipient.

Consecutive unplanned weight loss is weight loss of any amount every month over three consecutive months of the quarter. This can only be determined if the care recipient is weighed on all three occasions within the quarter, and at the end of the previous quarter (previous weight).

Previous weight is the weight recorded for each care recipient, in the final month of the previous quarter. The previous weight for significant and consecutive unplanned weight loss is the same weight measurement collected at the same time, in the final month of the previous quarter.

Starting weight is the weight recorded for each care recipient, in the first month of the quarter.

Middle weight is the mid-quarter weight recorded for each care recipient, recorded in the second month of the quarter.

Finishing weight is the final weight recorded for each care recipient, recorded in the final month of the current quarter. The finishing weight for significant and consecutive unplanned weight loss is the same weight measurement collected at the same time, in the final month of the current quarter.

For the purposes of the QI Program, **end-of-life care** is the terminal phase of life, where death is imminent and likely to occur within three months. This is sometimes referred to as *actively dying*.

11.3 Measurements and assessments for consecutive unplanned weight loss

The purpose of assessing a care recipient through the process set out below is to collect data relating to the consecutive unplanned weight loss quality indicator.

Pursuant to section 26(a) of the [Accountability Principles](#), approved providers must make assessments and measurements that are relevant to indicating the quality of residential care in accordance with the requirements listed below.

Note: Previous weights and finishing weights may have already been recorded for each care recipient as part of assessments and measurements made for significant unplanned weight loss. The previous weights and finishing weights can be used for consecutive unplanned weight loss and do not need to be collected again.

1. Using your service's weight records, identify each care recipient's previous weight (finishing weight from the previous quarter).
2. In the first month of the quarter, collect and record the starting weight of each care recipient residing at the service, using a calibrated scale.



Note: Always request the consent of care recipients to assess their body weight before making the assessment. If they withhold consent to be assessed for either a starting, middle or finishing weight, record this (see Step 5).

Note: Weigh care recipients at or around the same time each month.

Note: Weigh care recipients at around the same time of the day and wearing clothing of a similar weight (e.g. a single layer without coats or shoes).

3. In the second month of the quarter, collect and record the middle weight of each care recipient residing at the service, using a calibrated scale.
4. In the third and final month of the current quarter, collect and record the finishing weight for each care recipient residing at the service, using a calibrated scale.
5. Record the care recipients excluded because they withheld consent to be weighed on the starting, middle and/or finishing weight collection dates.
6. Record the care recipients excluded because they are receiving end-of-life care.
7. Record the care recipients excluded because they did not have the required weights recorded (e.g. previous, starting, middle and/or finishing weights). Include comments as to why the weight recording/s are absent (e.g. the care recipient entered the service during the quarter).
8. For each care recipient who provided consent, compare the previous, starting, middle, and finishing weights to determine if there has been weight loss in every month over three consecutive months of the quarter.

11.3.1 Inclusions for consecutive unplanned weight loss

All care recipients must be assessed for unplanned weight loss except those listed in [11.3.2. Exclusions for consecutive unplanned weight loss](#).

11.3.2 Exclusions for consecutive unplanned weight loss

Care recipients who:

- withhold consent to be weighed on the starting, middle and/or finishing weight collection dates; or
- are receiving end-of-life care; or
- do not have the required weights recorded (e.g. previous, starting, middle and/or finishing weights);

are excluded from assessments for consecutive weight loss but are reported under additional reporting requirements.

Note: Care recipients residing at the service who did not have a previous weight recorded (finishing weight for the previous quarter), must have a finishing weight collected and recorded using a calibrated scale in the final month of the current quarter through the process set out above.

11.4 Data reporting for consecutive unplanned weight loss






For the purposes of section 26(b) of the [Accountability Principles](#), approved providers must compile or otherwise derive information from these measurements and assessments that is relevant to indicating the quality of residential care. The information compiled or derived from the



measurements and assessments must not be personal information (within the meaning of the *Privacy Act 1988*) about any of the care recipients.

Approved providers must compile or derive information in accordance with the requirements below. Approved providers must ensure that the information compiled or derived in accordance with these requirements does not contain personal information about any of the care recipients.

Table 10: REQUIREMENTS FOR DATA REPORTING ON CONSECUTIVE UNPLANNED WEIGHT LOSS

1	Number of care recipients assessed for consecutive unplanned weight loss. Note: All care recipients must be assessed for unplanned weight loss except those listed in 11.3.2. Exclusions for consecutive unplanned weight loss.	
2	Number of care recipients excluded because they withheld consent to be weighed on the starting, middle and/or finishing weight collection dates.	
3	Number of care recipients excluded because they are receiving end-of-life care.	
4	Number of care recipients excluded because they did not have the required weights recorded (e.g. previous, starting, middle and/or finishing weights). Include comments as to why the weight recording/s are absent.	
5	Number of care recipients who experienced consecutive unplanned weight loss of any amount when comparing their previous, starting, middle and finishing weights.	

11.5 How to report consecutive unplanned weight loss

Pursuant to section 26(c) of the [Accountability Principles](#), approved providers must submit the quality indicator data into GPMS in order to make the information available to the Secretary.

11.6 How to record information in the Government Provider Management System (GPMS)

In giving information relating to consecutive unplanned weight loss to the Secretary pursuant to section 26(c) of the [Accountability Principles](#), approved providers must note care recipients who were excluded because they did not have a previous, starting, middle and/or finishing weight recorded, including the reason why the weight recording/s are absent, in the comments section in GPMS. Approved providers must ensure that the information compiled or derived in accordance with these requirements does not contain personal information about any of the care recipients.



11.7 Additional resources for consecutive unplanned weight loss

More information and resources related to consecutive unplanned weight loss are available at www.health.gov.au and in QI Program Manual 4.0 - Part B.



IMPORTANT NOTE

Any unplanned and unexpected weight loss must be investigated promptly and appropriate treatment commenced.

If a care recipient cannot be weighed, it is still good practice to monitor them using alternative means such as mid-arm or calf circumference. This ensures changes are identified and appropriate strategies put in place.



12 Falls and major injury

12.1 Overview of falls and major injury


A fall is an event that results in a person coming to rest inadvertently on the ground or floor or other lower level. This includes onto crash mats and from low beds.

- A fall resulting in major injury is a fall that meets this definition and results in one or more of the following: bone fractures, joint dislocations, closed head injuries with altered consciousness and/or subdural haematoma.⁵

While not all falls (with and without injury) can be prevented, the evidence suggests that fall rates can be reduced with interventions such as standard and individualised fall prevention strategies, physiotherapy, medication reviews and occupational therapy, among others. Dignity of risk should also be promoted consistently with consumer choice and control. It is considered critical to routinely screen for falls risk and to monitor the outcomes of falls prevention programs and interventions.

Approved providers of residential care services must collect and report on falls and major injury data quarterly, according to the requirements set out in this Manual.

Table 11: FALLS AND MAJOR INJURY QUALITY INDICATOR OVERVIEW

 Percentage of care recipients who experienced one or more falls Percentage of care recipients who experienced one or more falls resulting in major injury	Collection <ul style="list-style-type: none">• A single review of the care records of each care recipient for the entire quarter
	Quality indicator reporting <ul style="list-style-type: none">• Care recipients who experienced one or more falls at the service during the quarter• Care recipients who experienced one or more falls at the service resulting in major injury during the quarter
	Additional reporting <ul style="list-style-type: none">• Care recipients assessed for falls and major injury
	Exclusions <ul style="list-style-type: none">• Care recipients who were absent from the service for the entire quarter

12.2 Key terms for falls and major injury

For the purposes of the QI Program, a **fall** is defined as an event that results in a person coming to rest inadvertently on the ground or floor or other lower level.⁶ This includes falls from a low bed and onto a crash mat.

⁵ Xu D, Kane R and Arling G (2019), Relationship between nursing home quality indicators and potentially preventable hospitalisation, *BMJ Quality & Safety*, vol. 28(7), p. 524–533.

⁶ World Health Organisation (2007), *WHO global report on falls prevention in older age*, WHO, France.



A **fall resulting in major injury** is a fall that meets the definition above **and** results in one or more of the following:

- bone fractures;
- joint dislocations;
- closed head injuries with altered consciousness; and/or
- subdural haematoma.⁷

Falls resulting in major injury that occurred while the care recipient was away from the service and not under direct supervision of service staff are not included.

12.3 Measurements and assessments for falls and major injury

The purpose of assessing a care recipient through the process set out below is to collect data relating to the falls and major injury quality indicator.

Pursuant to section 26(a) of the [Accountability Principles](#), approved providers must make assessments and measurements that are relevant to indicating the quality of residential care in accordance with the requirements listed below.

1. The collection date must take place in the 21 days after the end of the quarter, in order to review records for the entire quarter.
2. Record the care recipients whose records are reviewed for the quarter, to assess for falls, and falls resulting in major injury. All care recipients residing at the service during the quarter should be included.
3. Record the care recipients excluded because they were absent from the service for the entire quarter (e.g. the care recipient was hospitalised for the entire quarter).
4. Record whether each care recipient experienced one or more falls at the service during the quarter.

Note: Care recipients who only experienced a fall or fall resulting in major injury that occurred while the care recipient was away from the service and not under direct supervision of service staff are excluded from these counts.

5. Record whether each care recipient experienced one or more falls at the service, resulting in major injury, during the quarter.

12.3.1 Inclusions for falls and major injury

All care recipients must be assessed for falls and major injury except those listed in [12.3.2. Exclusions for falls and major injury](#).

12.3.2 Exclusions for falls and major injury

Care recipients who were absent from the service for the entire quarter, are excluded from assessment for falls and major injury, but are reported under additional reporting requirements.

⁷ Xu D, Kane R, and Arling G (2019), Relationship between nursing home quality indicators and potentially preventable hospitalisation, *BMJ Quality & Safety*, vol. 28(7), p. 524–533.




Note: Falls resulting in major injury that occurred while the care recipient was away from the service are not included for the purposes of assessment or reporting.

12.4 Data reporting for falls and major injury

Pursuant to section 26(b) of the [Accountability Principles](#), approved providers must compile or otherwise derive information from these measurements and assessments that is relevant to indicating the quality of residential care. The information compiled or derived from the measurements and assessments must not be personal information (within the meaning of the *Privacy Act 1988*) about any of the care recipients.

Approved providers must compile or derive information in accordance with the requirements below. Approved providers must ensure that the information compiled or derived in accordance with these requirements does not contain personal information about any of the care recipients.

Table 12: REQUIREMENTS FOR DATA REPORTING ON FALLS AND MAJOR INJURY

1	Number of care recipients whose records were assessed for falls and major injury. Note: All care recipients must be assessed for falls and major injury except those listed in 12.3.2. Exclusions for falls and major injury.	
2	Number of care recipients excluded because they were absent from the service for the entire quarter.	
3	Number of care recipients who experienced one or more falls at the service during the quarter.	
4	Number of care recipients who experienced one or more falls at the service resulting in major injury during the quarter.	

12.5 How to report falls and major injury

Pursuant to section 26(c) of the [Accountability Principles](#), approved providers must submit the quality indicator data into GPMS in order to make the information available to the Secretary.

12.6 Additional resources for falls and major injury

More information and resources related to falls and major injury are available at www.health.gov.au and in QI Program Manual 4.0 - Part B.



13 Medication management – polypharmacy

Medication management plays a critical role in achieving quality of care for older people in aged care and hospital settings. The medication management quality indicator is reported against:

1. medication management – polypharmacy (this section), and
2. medication management – antipsychotics (see Section 14 of this Manual).


Approved providers are required to collect and record data for each category.

13.1 Overview of polypharmacy

Polypharmacy is defined as the prescription of nine or more medications to a care recipient. Regular monitoring of polypharmacy is important because polypharmacy has been associated with reduced quality of life and harms such as adverse drug events, cognitive decline, and hospitalisation.

Approved providers of residential care services must collect and report on polypharmacy data quarterly, according to the requirements set out in this Manual.

Table 13: MEDICATION MANAGEMENT – POLYPHARMACY QUALITY INDICATOR OVERVIEW

 Percentage of care recipients who were prescribed nine or more medications	Collection <ul style="list-style-type: none">• A single review of medication charts and/or administration records for each care recipient on a selected collection date every quarter
	Quality indicator reporting <ul style="list-style-type: none">• Care recipients who were prescribed nine or more medications
	Additional reporting <ul style="list-style-type: none">• Care recipients assessed for polypharmacy• Collection date
	Exclusions <ul style="list-style-type: none">• Care recipients admitted in hospital on the collection date

13.2 Key terms for polypharmacy

For the purposes of the QI Program, **medication** is defined as a chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease or otherwise enhancing the physical and/or mental welfare of people. For the purpose of the QI Program, it includes prescription and non-prescription medicines, irrespective of the administered route.

For the purposes of the QI Program, **polypharmacy** is defined as the prescription of nine or more medications to a care recipient.

For the purposes of the QI Program, any medication with an active ingredient is counted in the polypharmacy quality indicator, except for those listed below which must not be included in the count of medications:

- Lotions, creams or ointments used in skin and wound care;



- Dietary supplements, including those containing vitamins;
- Short-term medications, such as antibiotics or temporary eye drops; and
- PRN medications.

Different dosages of the same medicine must not be counted as different medications.

13.3 Measurements and assessments for polypharmacy

The purpose of assessing a care recipient through the process set out below is to collect data relating to the polypharmacy quality indicator.

Pursuant to section 26(a) of the [Accountability Principles](#), approved providers must make assessments and measurements that are relevant to indicating the quality of residential care in accordance with the requirements listed below.

1. Identify and record a collection date (DD/MM/YYYY) for the quarter.
2. Record the care recipients whose medication charts and/or administration records are reviewed to assess for polypharmacy. All care recipients residing at the service on the collection date must be included in the assessment.

Note: The audit for polypharmacy will be completed using each care recipient's medication charts and/or administration records as they are on the identified collection date.

3. Record the care recipients excluded because they were not assessed due to hospital admission on the collection date.
4. Review each care recipient's medication chart and/or administration records as on the collection date and record whether each care recipient was prescribed nine or more medications.

Note: It may not be feasible to conduct the medication chart/administration record audit for all care recipients on a single day. The review may be spread out over several days, however the review of medication charts and/or administration records must always be as they were on the identified collection date.

13.3.1 Inclusions for polypharmacy

All care recipients must be assessed for medication management except those listed in [13.3.2. Exclusions for polypharmacy](#).

13.3.2 Exclusions for polypharmacy

Care recipients who were admitted in hospital on the collection date, are excluded from assessment for polypharmacy, but are reported under additional reporting requirements.





13.4 Data reporting for polypharmacy

Pursuant to section 26(b) of the [Accountability Principles](#), approved providers must compile or otherwise derive information from these measurements and assessments that is relevant to indicating the quality of residential care. The information compiled or derived from the measurements and assessments must not be personal information (within the meaning of the Privacy Act 1988) about any of the care recipients.



Approved providers must compile or derive information in accordance with the requirements below. Approved providers must ensure that the information compiled or derived in accordance with these requirements does not contain personal information about any of the care recipients.

Table 3: Requirements for DATA REPORTING ON polypharmacy

1	The collection date for the quarter.	
2	Number of care recipients assessed for polypharmacy. Note: All care recipients must be assessed for medication management except those listed in 13.3.2. Exclusions for polypharmacy.	
3	Number of care recipients excluded because they were admitted in hospital on the collection date.	
4	Number of care recipients prescribed nine or more medications based on a review of their medication charts and/or administration records as they are on the collection date.	

13.5 How to report polypharmacy

Pursuant to section 26(c) of the [Accountability Principles](#), approved providers must submit the quality indicator data into GPMS in order to make the information available to the Secretary.

13.6 Additional resources for polypharmacy

More information and resources related to polypharmacy are available at www.health.gov.au and in QI Program Manual 4.0 - Part B.



14 Medication management – antipsychotics

Medication management plays a critical role in achieving quality of care for older people in aged care and hospital settings. The medication management quality indicator is reported against:


1. medication management – polypharmacy (see Section 13 of this Manual), and
2. medication management – antipsychotics (this section).

Approved providers are required to collect and record data for each category.

14.1 Overview of antipsychotics

Antipsychotics are medications prescribed for the treatment of a diagnosed condition of psychosis. Regular monitoring of the use of antipsychotics is important because inappropriate use of certain medication classes, such as antipsychotics, has been shown to be associated with poor health outcomes. Approved providers of residential care services must collect and report on antipsychotics data quarterly, according to the requirements set out in this Manual.

Table 4: Medication management – antipsychotics quality indicator overview

 Percentage of care recipients who received antipsychotic medications	Collection <ul style="list-style-type: none">• A seven-day medication chart and/or administration record review for each care recipient every quarter
	Quality indicator reporting <ul style="list-style-type: none">• Care recipients who received an antipsychotic medication
	Additional reporting <ul style="list-style-type: none">• Care recipients assessed for antipsychotic medications• Care recipients who received an antipsychotic medication for a diagnosed condition of psychosis• Collection date
	Exclusions <ul style="list-style-type: none">• Care recipients who were admitted in hospital for the entire seven-day assessment period

14.2 Key terms for antipsychotics

For the purposes of the QI Program, **medication** is defined as a chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease or otherwise enhancing the physical and/or mental welfare of people. For the purpose of the QI Program, it includes prescription and non-prescription medicines irrespective of the administered route.

Diagnosed by a medical doctor, **psychosis** is characterised by symptoms such as delusions, hallucinations, and perceptual disturbances, and by the severe disruption of ordinary behaviours (adapted from the ICD-10-AM, 2017).



Disorders where there may be a **diagnosed condition of psychosis** include: schizophrenia bipolar disorder, Huntington's chorea, delusions and hallucinations. End-of-life care recipients may also experience psychosis.

A non-exhaustive list of **antipsychotic medications** is available in QI Program Manual 4.0 - Part B.

14.3 Measurements and assessments for antipsychotics

The purpose of assessing a care recipient through the process set out below is to collect data relating to the antipsychotics quality indicator.

Pursuant to section 26(a) of the [Accountability Principles](#), approved providers must make assessments and measurements that are relevant to indicating the quality of residential care in accordance with the requirements listed below.

1. Identify and record a collection date (DD/MM/YYYY) during the quarter – between the second week and end of the quarter. The collection date and the six days prior will be the assessment period for which all care recipient medication charts and administration records are reviewed for antipsychotic medications.

Note: The collection date must be varied between quarters and must not be identified to, or conducted by, staff directly involved in care.

2. Record the care recipients whose medication charts and/or administration records are reviewed to assess for receipt of antipsychotic medications over the seven-day assessment period. All care recipients residing at the service during the seven-day assessment period must be included in the assessment.
3. Record the care recipients excluded because they were admitted in hospital for the entire seven-day assessment period.

Note: This is the only basis for exclusion, as it is possible that the medication being received by the care recipient is different from that included in their medication charts.

4. Review each care recipient's medication charts and/or administration records of the seven-day assessment period and record whether each care recipient received an antipsychotic medication. This includes PRN medications.
5. Of those care recipients who received an antipsychotic medication in Step 4, also record whether the care recipient has a medically diagnosed condition of psychosis by performing a review of their medical records.

Note: It may not be feasible to conduct the medication chart/administration record audit for all care recipients on a single day. The review may be spread out over several days however, the review of medication charts and/or administration records must always be as they were on the identified collection date.

14.3.1 Inclusions for antipsychotics

All care recipients must be assessed for medication management except those listed in [14.3.2. Exclusions for antipsychotics](#).



14.3.2 Exclusions for antipsychotics






Care recipients who were admitted in hospital for the entire seven-day assessment period, are excluded from assessment for antipsychotics, but are reported under additional reporting requirements.

14.4 Data reporting for antipsychotics

Pursuant to section 26(b) of the [Accountability Principles](#), approved providers must compile or otherwise derive information from these measurements and assessments that is relevant to indicating the quality of residential care. The information compiled or derived from the measurements and assessments must not be personal information (within the meaning of the Privacy Act 1988) about any of the care recipients.

Approved providers must compile or derive information in accordance with the requirements below. Approved providers must ensure that the information compiled or derived in accordance with these requirements does not contain personal information about any of the care recipients.

Table 16: Requirements for data reporting on antipsychotics

1	The collection date for the quarter.	
2	Number of care recipients assessed for antipsychotic medications. Note: All care recipients must be assessed for medication management except those listed in 14.3.2. Exclusions for antipsychotics.	
3	Number of care recipients excluded because they were admitted in hospital for the entire seven-day assessment period.	
4	Number of care recipients who received an antipsychotic medication.	
5	Number of care recipients who received an antipsychotic medication for a medically diagnosed condition of psychosis.	

14.5 How to report antipsychotics

Pursuant to section 26(c) of the [Accountability Principles](#), approved providers must submit the quality indicator data into GPMS in order to make the information available to the Secretary.

14.6 Additional resources for antipsychotics

More information and resources related to antipsychotics are available at www.health.gov.au and in QI Program Manual 4.0 - Part B.



15 Activities of daily living


15.1 Overview of activities of daily living

Activities of daily living (ADLs) can be used to measure people's ability to move and care for themselves. These include management of personal hygiene, dressing, going to the toilet and eating. ADLs are important to maintain independence, health status and quality of life. Aged care services can assist care recipients to actively participate in these activities to improve or maintain function or slow the rate of decline.

The Barthel Index of Activities of Daily Living⁸ (ADL assessment) is the assessment tool used for the purposes of the QI Program, included in [Appendix A](#).

Approved providers of residential care services must collect and report on activities of daily living data quarterly, according to the requirements set out in this Manual.

Table 17: ACTIVITIES OF DAILY LIVING QUALITY INDICATOR OVERVIEW

 Percentage of care recipients who experienced a decline in activities of daily living	Collection <ul style="list-style-type: none">A single assessment for each care recipient is completed around the same time every quarter and compared to their ADL assessment total score in the previous quarter to determine decline
	Quality indicator reporting <ul style="list-style-type: none">Care recipients who experienced a decline in their ADL assessment total score of one or more points
	Additional reporting <ul style="list-style-type: none">Care recipients assessed for ADL functionCare recipients with an ADL assessment total score of zero in the previous quarter
	Exclusions <ul style="list-style-type: none">Care recipients who are receiving end-of-life careCare recipients who were absent from the service for the entire quarterCare recipients who did not have an ADL assessment total score recorded for the previous quarter and comments providing explanation as to why recording is absent

15.2 Key terms for activities of daily living

The Barthel Index of Activities of Daily Living assessment tool (included in [Appendix A](#)) is comprised of 10 items. For each item, choose the statement most closely corresponding to a care

⁸ Collin C, Wade DT, Davies S, and Horne V (1988), The Barthel ADL Index: a reliability study, *International Disability Studies*; vol. 10(2), p. 61–63.



recipient's current level of ability. The score for each statement is added together to give the ADL assessment total score.

For the purposes of the QI Program, **decline in ADLs** is defined as a decline in ADL assessment total score of one or more points. This is determined by comparing the ADL assessment total score from the previous quarter and the ADL assessment total score from the current quarter. Both ADL assessment total scores must be available to provide this result.

For the purposes of the QI Program, **end-of-life care** is the terminal phase of life, where death is imminent and likely to occur within three months. This is sometimes referred to as actively dying.

15.3 Measurements and assessments for activities of daily living

The purpose of assessing a care recipient through the process set out below is to collect data relating to the ADL quality indicator.

Pursuant to section 26(a) of the [Accountability Principles](#), approved providers must make assessments and measurements that are relevant to indicating the quality of residential care in accordance with the requirements listed below.

1. Using your service's care records, identify each care recipient's ADL assessment total score from the previous quarter.
2. Around the same time each quarter, conduct an ADL assessment for each care recipient by completing all questions in the Barthel Index of Activities of Daily Living assessment tool, included in Appendix A.

Note: Barthel Index of Activities of Daily Living scoring is based on the care recipient's actual performance over the previous 24–48 hours, noting longer periods will be relevant for some items (e.g. bowel and bladder).

Note: A care recipient's performance for each of the ten items is established using the best available evidence. This can include using existing knowledge of the care recipient obtained through routine personal care, asking the care recipient, referring to care records or by direct observation. Direct testing is not required.

3. Record the care recipients excluded because they were receiving end-of-life care.
4. Record the care recipients excluded because they were absent from the service during the entire quarter (e.g. the care recipient was hospitalised for the entire quarter).
5. Record the care recipients excluded because they did not have an ADL assessment total score recorded for the previous quarter. Include comments as to why the previous recording is absent (e.g. the care recipient was hospitalised for the entire previous quarter).
6. Record the care recipients with an ADL assessment total score of zero in the previous quarter.
7. Record the ADL assessment total score for each care recipient.
8. For each care recipient, compare the previous quarter ADL assessment total score with the current ADL assessment total score, to determine if the care recipient experienced a decline of one or more points. Record the number of care recipients who experienced a decline in ADL assessment total score of one or more points.



15.3.1 Inclusions for activities of daily living

All care recipients at the service must be assessed for ADL function, except for those listed in [15.3.2 Exclusions for activities of daily living](#).

15.3.2 Exclusions for activities of daily living

Care recipients who:

- were receiving end-of-life care for the entire quarter; or
- were absent from the service for the entire quarter; or
- did not have a previous quarter ADL assessment total score;

are excluded from the assessment for ADLs, but are reported under additional reporting requirements.

Note: Care recipients residing at the service who did not have a previous quarter ADL assessment total score recorded, must have an ADL assessment conducted in the current quarter, through the process set out above.

15.4 Data reporting for activities of daily living



Pursuant to section 26(b) of the [Accountability Principles](#), approved providers must compile or otherwise derive information from these measurements and assessments that is relevant to indicating the quality of residential care. The information compiled or derived from the measurements and assessments must not be personal information (within the meaning of the *Privacy Act 1988*) about any of the care recipients.

Approved providers must compile or derive information in accordance with the requirements below. Approved providers must ensure that the information compiled or derived in accordance with these requirements does not contain personal information about any of the care recipients.

Table 5: Requirements for data reporting ON Activities of daily living

1	Number of care recipients assessed for ADL function. Note: All care recipients must be assessed for ADL function, except for those listed in 15.3.2 Exclusions for activities of daily living.	
2	Number of care recipients excluded because they were receiving end-of-life care.	
3	Number of care recipients excluded because they were absent from the service for the entire quarter.	
4	Number of care recipients excluded because they did not have an ADL assessment total score recorded for the previous quarter. Include comments as to why the previous recording is absent.	



5	Number of care recipients with an ADL assessment total score of zero in the previous quarter.	
6	Number of care recipients who experienced a decline in ADL assessment total score of one or more points.	

15.5 How to report activities of daily living

Pursuant to section 26(c) of the [Accountability Principles](#), approved providers must submit the quality indicator data into GPMS in order to make the information available to the Secretary.

15.6 How to record information in Government Provider Management System (GPMS)

In giving information relating to activities of daily living to the Secretary pursuant to section 26(c) of the [Accountability Principles](#), approved providers must note care recipients who were excluded because they did not have a previous ADL assessment total score recorded in the previous quarter, including the reason why the recording is absent, in the comments section in GPMS. Approved providers must ensure that the information compiled or derived in accordance with these requirements does not contain personal information about any of the care recipients.

15.7 Additional resources for activities of daily living

More information and resources related to ADLs are included in [Appendix A](#), and are available at www.health.gov.au and in QI Program Manual 4.0 - Part B.



16 Incontinence care

16.1 Overview of incontinence care

Continence is the ability to control the bladder and bowel. Incontinence is the loss of bladder and bowel control, which can impact independence, health and quality of life. Aged care providers can ensure people have access to the right treatments and support to assist bladder and bowel control.

Incontinence associated dermatitis (IAD) is common in residential care⁹. There are several risk factors for the development of IAD, including incontinence of urine, faeces (or both), pre-existing skin conditions, poor mobility, and inability to maintain personal hygiene.

The Ghent Global IAD Categorisation Tool¹⁰ is the assessment tool used for the purposes of the QI Program, included in [Appendix B](#).


Approved providers of residential care services must collect and report on incontinence care data quarterly, according to the requirements set out in this Manual.

⁹ Van Damme N, Van den Bussche K, De Meyer D, Van Hecke A, Verhaeghe S, and Beeckman D, (2017), Independent risk factors for the development of skin erosion due to incontinence (incontinence-associated dermatitis category 2) in nursing home residents: results from a multivariate binary regression analysis, *International Wound Journal*, vol. 14(5), p. 801–810.

¹⁰ Beeckman D, Van den Bussche K, Alves P, Beele H, Ciprandi G, Coyer F, de Groot T, De Meyer D, Dunk AM, Fourie A, García-Molina P, Gray M, Iblasi A, Jelnes R, Johansen E, Karadağ A, LeBlanc K, Kis Dadara Z, Long MA, Meaume S, Pokorna A, Romanelli M, Ruppert S, Schoonhoven L, Smet S, Smith C, Steininger A, Stockmayr M, Van Damme N, Voegeli D, Van Hecke A, Verhaeghe S, Woo K and Kottner J (2017), [The Ghent Global IAD Categorisation Tool \(GLOBIAD\)](#), Skin Integrity Research Group - Ghent University.



Table 19: INCONTINENCE CARE QUALITY INDICATOR OVERVIEW

 <p>Percentage of care recipients who experienced incontinence associated dermatitis</p>	<p>Collection</p> <ul style="list-style-type: none"> A single assessment for each care recipient, around the same time every quarter as part of routine care
	<p>Quality indicator reporting</p> <ul style="list-style-type: none"> Care recipients with incontinence who experienced IAD Care recipients who experienced IAD, reported against each of the four sub-categories: <ul style="list-style-type: none"> 1A: Persistent redness without clinical signs of infection 1B: Persistent redness with clinical signs of infection 2A: Skin loss without clinical signs of infection 2B: Skin loss with clinical signs of infection
	<p>Additional reporting</p> <ul style="list-style-type: none"> Care recipients assessed for incontinence care Care recipients with incontinence
	<p>Exclusions for incontinence care</p> <ul style="list-style-type: none"> Care recipients who were absent from the service for the entire quarter <p>Exclusions for IAD assessment</p> <ul style="list-style-type: none"> Care recipients who did not have incontinence

16.2 Key terms for incontinence care

For the purposes of the QI Program, **incontinence** is any accidental or involuntary loss of urine from the bladder (urinary incontinence) or faeces from the bowel (faecal incontinence). Incontinence can range in severity from a small leak to complete loss of bladder or bowel control.

For the purposes of the QI Program, a care recipient has **incontinence** if bladder incontinence occurs more than once a day or bowel incontinence more than once a week.

For the purposes of the QI Program, a care recipient has **incontinence** if they require urinary catheters for passing urine.

Incontinence associated dermatitis (IAD) is defined in the Ghent Global IAD Categorisation Tool as a specific type of irritant contact dermatitis characterised by erythema and oedema of the peri-anal or genital skin. In some cases, IAD is accompanied by bullae, erosion or secondary cutaneous infection. The Ghent Global IAD Categorisation Tool includes the following IAD categories:

Table 20: SUB-CATEGORIES OF IAD

CATEGORY 1 PERSISTENT REDNESS

- 1A – Persistent redness without clinical signs of infection
- 1B – Persistent redness with clinical signs of infection



CATEGORY 2 SKIN LOSS

- 2A – Skin loss without clinical signs of infection
- 2B – Skin loss with clinical signs of infection

Please refer to the Ghent Global IAD Categorisation Tool, included in [Appendix B](#). This includes further guidance to inform clinical assessment of persistent redness, skin loss and signs of infection.

Note: IAD and pressure injuries have a number of common risk factors. IAD can be commonly misdiagnosed as a pressure injury. Differentiation between IAD and pressure injuries requires accurate assessment, including identification of the cause of the skin damage.

16.3 Measurements and assessments for incontinence care

The purpose of assessing a care recipient through the process set out below is to collect data relating to the incontinence care quality indicator.

Pursuant to section 26(a) of the [Accountability Principles](#), approved providers must make assessments and measurements that are relevant to indicating the quality of residential care in accordance with the requirements listed below.

1. Identify a date once every quarter to assess each care recipient residing at the service for incontinence as part of routine care. This assessment should be on or around the same time each quarter.

Note: It may not be feasible to assess all care recipients on a single day. The review may be spread out over several days to ensure all care recipients residing at the service during the quarter are included.

2. Record the care recipients excluded because they were absent from the service for the entire quarter (e.g. the care recipient was hospitalised for the entire quarter).
3. Record the care recipients excluded from IAD assessment because they did not have incontinence.

Note: Incontinence related care and skin integrity should be monitored as part of the care recipient's routine personal care (e.g. bathing and toileting).

4. Record each care recipient who had incontinence.
5. For each care recipient recorded at Step 4 with incontinence, record if they experienced IAD.

Note: IAD should be monitored as part of the care recipient's routine personal care (e.g. bathing and toileting).

6. Record each care recipient with incontinence who experienced IAD against each of the four sub-categories in the Ghent Global IAD Categorisation Tool:
 - 1A: Persistent redness without clinical signs of infection
 - 1B: Persistent redness with clinical signs of infection
 - 2A: Skin loss without clinical signs of infection
 - 2B: Skin loss with clinical signs of infection



Note: An IAD assessment should be conducted by staff who understand the Ghent Global IAD Categorisation Tool and have the necessary skills and experience to do so accurately and safely. It may be appropriate for a personal care worker to observe for signs of redness or skin loss during routine personal care and if identified, escalate to appropriately trained staff for further assessment. Approved providers must consult with a suitably qualified health practitioner if there is uncertainty about the presence or severity of IAD.

Note: All instances of IAD must be recorded at this step, irrespective of where it was acquired.

16.3.1 Inclusions for incontinence care

All care recipients must be assessed for incontinence care except for those listed in [16.3.2 Exclusions for incontinence care](#).

16.3.2 Exclusions for incontinence care

Care recipients who were absent from the service for the entire quarter, are excluded from the assessment for incontinence care, but are reported under additional reporting requirements.

16.3.3 Exclusions for IAD assessment





Care recipients who did not have incontinence, are excluded from the assessment for IAD, but are reported under additional reporting requirements.

16.4 Data reporting for incontinence care



Pursuant to section 26(b) of the [Accountability Principles](#), approved providers must compile or otherwise derive information from these measurements and assessments that is relevant to indicating the quality of residential care. The information compiled or derived from the measurements and assessments must not be personal information (within the meaning of the *Privacy Act 1988*) about any of the care recipients.

Approved providers must compile or derive information in accordance with the requirements below. Approved providers must ensure that the information compiled or derived in accordance with these requirements does not contain personal information about any of the care recipients.

Table 21: REQUIREMENTS FOR DATA REPORTING ON INCONTINENCE CARE

1	Number of care recipients assessed for incontinence care. Note: All care recipients must be assessed for incontinence care except for those listed in 16.3.2 Exclusions for incontinence care.	
2	Number of care recipients excluded because they were absent from the service for the entire quarter.	
3	Number of care recipients excluded from IAD assessment because they did not have incontinence.	
4	Number of care recipients with incontinence.	



5	Number of care recipients with incontinence who experienced IAD.	
6	<p>Number of care recipients with incontinence who experienced IAD, reported against each of the four IAD sub-categories:</p> <ul style="list-style-type: none">• 1A: Persistent redness without clinical signs of infection• 1B: Persistent redness with clinical signs of infection• 2A: Skin loss without clinical signs of infection• 2B: Skin loss with clinical signs of infection.	

16.5 How to report incontinence care

Pursuant to section 26(c) of the [Accountability Principles](#), approved providers must submit the quality indicator data into GPMS in order to make the information available to the Secretary.

Approved providers must consult with a suitably qualified health practitioner if there is uncertainty about the presence or subcategory of incontinence associated dermatitis.

16.6 Additional resources for incontinence care

More information and resources related to incontinence care are included in Appendix B, and are available at www.health.gov.au and in QI Program Manual 4.0 - Part B.



17 Hospitalisation

17.1 Overview of hospitalisation

Many emergency department presentations or admissions to hospital are potentially preventable if people have timely access to appropriate healthcare services. Excessive transfers of care recipients to the emergency department may indicate poor care quality and access.

Approved providers of residential care services must collect and report on hospitalisation data quarterly, according to the requirements set out in this Manual.

Table 6: Hospitalisation quality indicator overview

 <p>Percentage of care recipients who had one or more emergency department presentations</p> <p>Percentage of care recipients who had one or more emergency department presentations or hospital admissions</p>	Collection <ul style="list-style-type: none">• A single review of the care records for each care recipient for the entire quarter
	Quality indicator reporting <ul style="list-style-type: none">• Care recipients who had one or more emergency department presentations during the quarter
	Additional reporting <ul style="list-style-type: none">• Care recipients assessed for hospitalisation• Care recipients who had one or more emergency department presentations or hospital admissions during the quarter
	Exclusions <ul style="list-style-type: none">• Care recipients who were absent from the service for the entire quarter

17.2 Key terms for hospitalisation

For the purposes of the QI Program, an **emergency department presentation** occurs when a care recipient presents to an emergency department or urgent care centre. This includes all emergency department presentations occurring in person, or via a technology enabled platform (e.g. telehealth or virtual).

For the purposes of the QI Program, a **hospital admission** occurs when a care recipient is accepted by a hospital inpatient speciality service for ongoing management. This includes all hospital admissions, planned or unplanned, of any length (e.g. same day or overnight), occurring in any location (e.g. hospital or hospital in the home).

Medical appointments at a hospital are not reported as part of the hospitalisation quality indicator. Therefore, care recipients attending hospital for medical appointments, for example dialysis three



times a week or monthly appointments for chemotherapy, are not included in the reporting for this quality indicator.

It is important to note, if a care recipient is admitted to hospital after the medial appointment, they should be included in the additional reporting requirements for the hospitalisation quality indicator.

17.3 Measurements and assessments for hospitalisation

The purpose of assessing a care recipient through the process set out below is to collect data relating to the hospitalisation quality indicator.

Pursuant to section 26(a) of the [Accountability Principles](#), approved providers must make assessments and measurements that are relevant to indicating the quality of residential care in accordance with the requirements listed below.

1. The collection date must take place in the 21 days after the end of the quarter, in order to review records for the entire quarter.
2. Record the care recipients whose records are reviewed to assess for hospitalisation for the quarter. All care recipients residing at the service during the quarter should be included.
3. Record the care recipients excluded because they were absent from the service for the entire quarter (e.g. the care recipient was hospitalised for the entire quarter).
4. Record the care recipients with one or more emergency department presentations during the quarter.
5. Record the care recipients with one or more emergency department presentations or hospital admissions during the quarter.

17.3.1 Inclusions for hospitalisation

All care recipients must be assessed for hospitalisation except those listed in [17.3.2 Exclusions for hospitalisation](#).

17.3.2 Exclusions for hospitalisation

Care recipients who were absent from the service for the entire quarter, are excluded from the assessment for hospitalisation, but are reported under additional reporting requirements.





17.4 Data reporting for hospitalisation

Pursuant to section 26(b) of the [Accountability Principles](#), approved providers must compile or otherwise derive information from these measurements and assessments that is relevant to indicating the quality of residential care. The information compiled or derived from the measurements and assessments must not be personal information (within the meaning of the *Privacy Act 1988*) about any of the care recipients.

Approved providers must compile or derive information in accordance with the requirements below. Approved providers must ensure that the information compiled or derived in accordance with these requirements does not contain personal information about any of the care recipients.



Table 7: Requirements for data reporting on hospitalisation

1	Number of care recipients assessed for hospitalisation. Note: All care recipients must be assessed for hospitalisation except those listed in 17.3.2 Exclusions for hospitalisation.	
2	Number of care recipients excluded because they were absent from the service for the entire quarter.	
3	Number of care recipients who had one or more emergency department presentations during the quarter.	
4	Number of care recipients who had one or more emergency department presentations or hospital admissions during the quarter.	

17.5 How to report hospitalisation

Pursuant to section 26(c) of the [Accountability Principles](#), approved providers must submit the quality indicator data into GPMS in order to make the information available to the Secretary.

17.6 Additional resources for hospitalisation

More information and resources related to hospitalisation are available at www.health.gov.au and in QI Program Manual 4.0 - Part B.




18 Workforce

18.1 Overview of workforce

The aged care workforce is critical to providing quality services to meet the needs of older Australians. There are well established links between the capacity of aged care staff and the quality of care provided. Many older Australians, their families and representatives have reported that continuity of care is the critical element for care recipient wellbeing in residential care.

Approved providers of residential care services must collect and report on workforce data quarterly, according to the requirements set out in this Manual.

Table 24: Workforce quality indicator overview

 Percentage of staff turnover	Collection
	<ul style="list-style-type: none">• A single review of staff records
	Quality Indicator Reporting
	<ul style="list-style-type: none">• Staff who were employed at the start of the quarter as:<ul style="list-style-type: none">○ service managers○ nurse practitioners or registered nurses○ enrolled nurses○ personal care staff or assistants in nursing• Staff who stopped working during the quarter as:<ul style="list-style-type: none">○ service managers○ nurse practitioners or registered nurses○ enrolled nurses○ personal care staff or assistants in nursing
	Additional reporting
	<ul style="list-style-type: none">• Staff who worked any hours during the previous quarter as:<ul style="list-style-type: none">○ service managers○ nurse practitioners or registered nurses○ enrolled nurses○ personal care staff or assistants in nursing

18.2 Key terms for workforce

For the purposes of the QI Program, staff are considered **employed** when they have worked at least 120 hours in the previous quarter.

Note: All staff that meet this definition are included, irrespective of the type of employment (e.g. this includes permanent, part-time, casual, contractors, and agency staff).

For the purposes of the QI Program, **staff who stopped working** refers to staff members who have a period of at least 60 consecutive days in the current quarter in which they have not worked at the service.



The definition of employed at the start of the current quarter for the purposes of the QI program data collection is: 'worked at least 120 hours at the service in the previous quarter'.

Therefore, a staff member who has worked no hours in the current quarter but worked at least 120 hours in the previous quarter, meets the definition of employed at the start of the current quarter, as well as the definition for staff who stopped working.

Service managers is defined as staff who manage the operations of a residential aged care service. This includes leading staff teams to ensure the provision of quality care, in line with the aged care standards.

Nurse practitioners is defined as staff who are registered as nurse practitioners with the Nursing and Midwifery Board of Australia.

Registered nurses is defined as staff who are registered as registered nurses with the Nursing and Midwifery Board of Australia.

Enrolled nurses is defined as staff who are registered as enrolled nurses with the Nursing and Midwifery Board of Australia.

Personal care staff is defined as staff who provide personalised care in a direct care role to care recipients. Common duties include working under the guidance and supervision of medical professionals, monitoring and communicating care recipient's condition to the Director of Nursing, personal hygiene, providing meals and other health and wellness related activities in accordance with the care recipient's care plan.

Assistants in nursing is defined as staff who provide personalised nursing care in a direct care role to care recipients. Common duties include working under the guidance and supervision of medical professionals, monitoring and communicating care recipient's condition to the Director of Nursing, personal hygiene, providing meals and other health and wellness related activities in accordance with the care recipient's care plan.

18.3 Measurements and assessments for workforce

The purpose of assessing a staff member through the process set out below is to collect data relating to the workforce quality indicator.

Pursuant to section 26(a) of the [Accountability Principles](#), approved providers must make assessments and measurements that are relevant to indicating the quality of residential care in accordance with the requirements listed below.

1. The collection date must take place in the 21 days after the end of the current quarter, in order to review records for the entire quarter.
2. Record the staff who worked any hours in the previous quarter as the following:
 - service managers;
 - nurse practitioners or registered nurses;
 - enrolled nurses; and
 - personal care staff or assistants in nursing
3. Record the staff who met the QI Program definition of *employed* as the following:
 - service managers;



- nurse practitioners or registered nurses;
- enrolled nurses; and
- personal care staff or assistants in nursing;

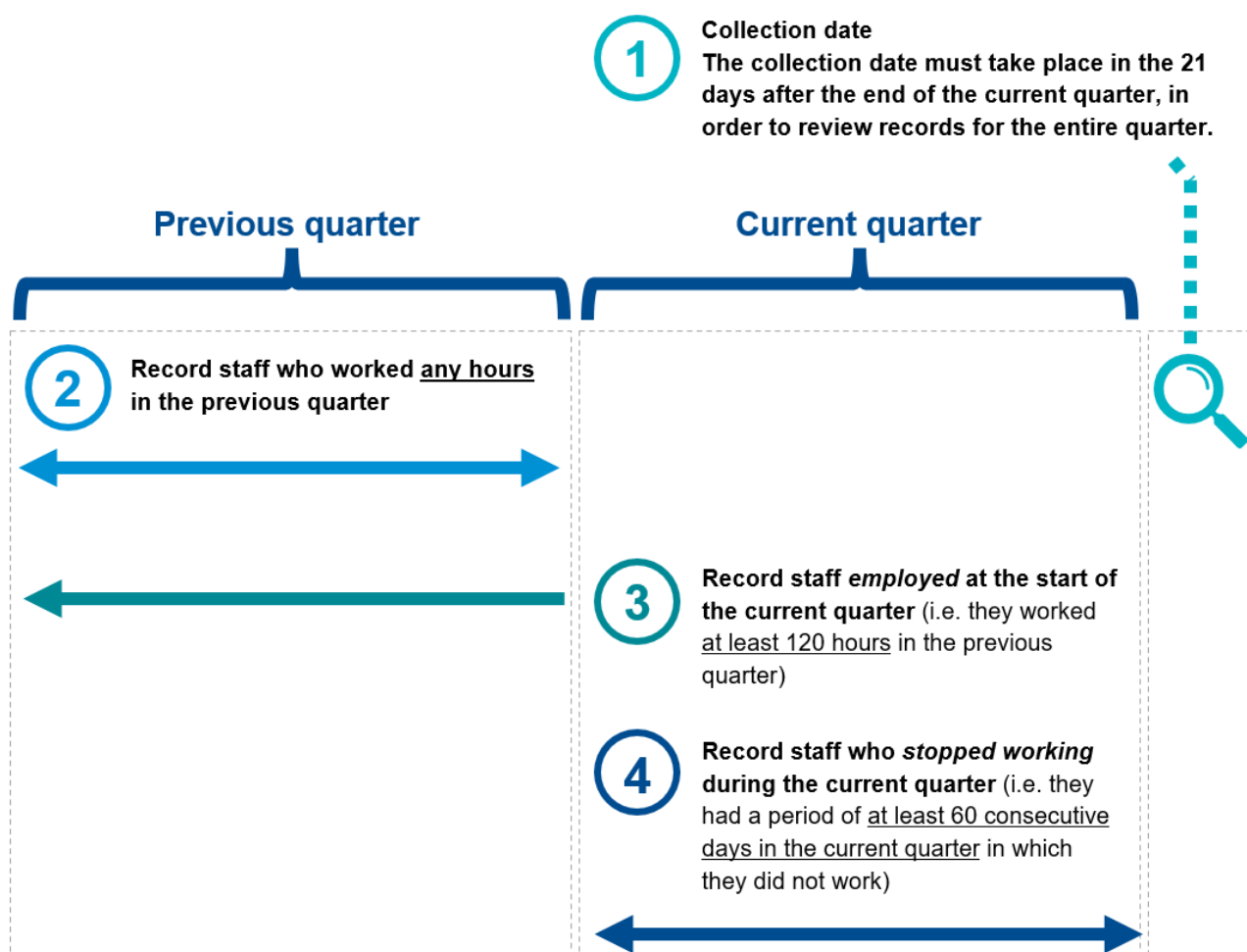
at the start of the current quarter (i.e. they worked at least 120 hours at the service in the previous quarter).

Note: Refer to [18.2 Key terms for workforce](#) for the definition of 'employed staff'.

4. For staff who were recorded under Step 3, record the staff who have stopped working during the current quarter (i.e. they had a period of at least 60 consecutive days in the current quarter in which they did not work at the service).

Note: Refer to [18.2 Key terms for workforce](#) for the definition of 'staff who stopped working'.

Figure 1: Summary of DATA COLLECTION STEPS FOR WORKFORCE



In respect of the above diagram, the collection date is 21 days after the end of the 'current quarter'. Therefore the 'current quarter' for the purposes of the workforce indicator would be the quarter that the approved provider is collecting the data for, not the quarter that the collection date falls within. For example, if the collection date was 21 July the current quarter would be Q4, 1 April to 30 June and the previous quarter would be Q3, 1 January to 31 March.



18.3.1 Inclusions for workforce

All staff who worked any hours as either service managers, nurse practitioners, registered nurses, enrolled nurses, personal care staff or assistants in nursing at the start of the quarter must be assessed for the workforce quality indicator.

Note: Refer to [18.2 Key terms for workforce](#).

18.3.2 Exclusions for workforce

Nil.



18.4 Data reporting for workforce

Approved providers must compile or derive information in accordance with the requirements below. Approved providers must ensure that the information compiled or derived in accordance with these requirements does not contain personal information (within the meaning of the *Privacy Act 1988*) about any of the staff members.

Table 25: REQUIREMENTS FOR DATA REPORTING ON WORKFORCE

1	Number of staff who worked any hours as service managers in the previous quarter.	
2	Number of staff who worked any hours as nurse practitioners or registered nurses in the previous quarter.	
3	Number of staff who worked any hours as enrolled nurses in the previous quarter.	
4	Number of staff who worked any hours as personal care staff or assistants in nursing in the previous quarter.	
5	Number of staff employed as service managers at the start of the quarter.	
6	Number of staff employed as nurse practitioners or registered nurses at the start of the quarter.	
7	Number of staff employed as enrolled nurses at the start of the quarter.	
8	Number of staff employed as personal care staff or assistants in nursing at the start of the quarter.	
9	Number of staff employed as service managers who stopped working during the quarter.	
10	Number of staff employed as nurse practitioners or registered nurses who stopped working during the quarter.	



11	Number of staff employed as enrolled nurses who stopped working during the quarter.	
12	Number of staff employed as personal care staff or assistants in nursing who stopped working during the quarter.	

18.5 How to report workforce

Pursuant to section 26(c) of the [Accountability Principles](#), approved providers must submit the quality indicator data into GPMS in order to make the information available to the Secretary.

18.6 Additional resources for workforce

More information and resources related to workforce are available at www.health.gov.au and in QI Program Manual 4.0 - Part B.



19 Consumer experience

19.1 Overview of consumer experience

Consumer experience is crucial in capturing the consumer voice of older Australians. The Quality-of-Care Experience Aged Care Consumers © *Flinders University 2022* (QCE-ACC)¹¹ tool was co-designed with older Australians to assess important aspects of consumer experience. The QCE-ACC is comprised of six questions focused on key attributes to the quality-of-care experience — respect and dignity, supported decision-making, skills of aged care staff, impact on health and wellbeing, social relationships and community connection, and confidence in lodging complaints.


The QCE-ACC is the consumer experience assessment tool used for the purposes of the QI Program, included in [Appendix C](#).

Approved providers of residential care services must collect and report on consumer experience data quarterly, according to the requirements set out in this Manual.

¹¹ Khadka, J, Ratcliffe, J, Chen, G, Kumaran, S, Milte, R, Hutchinson, C, Savvas, S and Batchelor, F (2020), *A new measure of quality of care in aged care: psychometric assessment, and validation of the Quality of Care Experience (QCE) questionnaire*, Caring Futures Institute, Flinders University, Adelaide.



Table 26: CONSUMER EXPERIENCE QUALITY INDICATOR OVERVIEW

 <p>Percentage of care recipients who report 'good' or 'excellent' experience of the service</p>	Collection <ul style="list-style-type: none">• A consumer experience assessment must be offered to each care recipient for completion, around the same time every quarter
	Quality indicator reporting <ul style="list-style-type: none">• Care recipients who reported consumer experience through each completion mode of the QCE-ACC (self-completion, interviewer facilitated completion or proxy-completion), scored against the categories:<ul style="list-style-type: none">○ 'Excellent' (care recipients who score between 22–24)○ 'Good' (care recipients who score between 19–21)
	Additional reporting <ul style="list-style-type: none">• Care recipients who were offered a consumer experience assessment for completion• Care recipients who reported consumer experience through each completion mode of the QCE-ACC (self-completion, interviewer facilitated completion or proxy-completion), scored against the categories:<ul style="list-style-type: none">○ 'Moderate' (care recipients who score between 14–18)○ 'Poor' (care recipients who score between 8–13)○ 'Very poor' (care recipients who score between 0–7)
	Exclusions <ul style="list-style-type: none">• Care recipients who were absent from the service for the entire quarter• Care recipients who did not choose to complete the consumer experience assessment for the entire quarter

19.2 Key terms for consumer experience

The Quality of Care Experience Aged Care Consumers© (QCE-ACC) tool asks care recipients to indicate their quality of care experience by selecting the most appropriate statement using a five or six point scale. This ranges from 'never' to 'always' for five of the six survey questions, with the question about complaints having a 'not applicable' option see [Appendix C](#).

The care recipient's scores for each of the six questions is added together to give a total score. The guidance provides a rescaling tool if a care recipient answers 'not applicable'. Once scored, these are then assigned to one of five categories describing overall consumer experience:

- **Excellent** consumer experience: where a care recipient scores between 22–24
- **Good** consumer experience: where a care recipient scores between 19–21
- **Moderate** consumer experience: where a care recipient scores between 14–18
- **Poor** consumer experience: where a care recipient scores between 8–13
- **Very poor** consumer experience: where a care recipient scores between 0–7.



Anonymous collection of QCE-ACC assessments is preferred and should be supported to the extent possible.

For the purposes of the QI Program, **self-completion** is when a care recipient independently completes the QCE-ACC Self-Complete Version. It is recommended the QCE-ACC is self-completed by all care recipients with capacity (e.g. care recipients with no or mild cognitive impairment). Approved providers are encouraged to facilitate anonymous, self-completion where possible, using the QCE-ACC Self-Complete Version.

Note: Where self-completion by a care recipient is not possible because they are unable to read the questions or write responses, interviewer facilitated completion is recommended (see below).

Note: Where self-completion and interviewer facilitated completion is not possible because a care recipient has moderate or severe cognitive impairment, proxy-completion is recommended (see below).

For the purposes of the QI Program, **interviewer facilitated completion** is when a care recipient requires additional support (e.g. support with reading the questions or writing responses) to facilitate completion using the QCE-ACC Interviewer Facilitated Version. The interviewer must not influence scoring by the care recipient and must use the QCE-ACC Interviewer Facilitated Version.

For the purposes of the QI Program, **proxy-completion** is when a care recipient is unable to answer on their own behalf (e.g. because of moderate or severe cognitive impairment) and the QCE-ACC Proxy Version is used by a person who knows the care recipient well and sees them regularly (e.g. informal carer, relative) to facilitate completion. The proxy respondent should answer based on their own knowledge of the care recipient and their quality of care experience at the time of administration using the QCE-ACC Proxy Version. It is only appropriate for a care worker or other employee at the service to act as proxy for the care recipient if a proxy with a more suitable relationship to the care recipient is unavailable.

19.3 Measurements and assessments for consumer experience

The purpose of assessing a care recipient through the process set out below is to collect data relating to the consumer experience quality indicator.

Pursuant to section 26(a) of the [Accountability Principles](#), approved providers must make assessments and measurements that are relevant to indicating the quality of residential care in accordance with the requirements listed below.

1.
 - a. Offer the QCE-ACC Self-Complete Version for self-completion to all suitable care recipients at the service at around the same time every quarter. The QCE-ACC Self-Complete Version can be self-completed by care recipients with no or mild cognitive impairment.
 - b. Arrange interviewer facilitated completion for all care recipients requiring assistance to complete the QCE-ACC (e.g. where the care recipient requires support with reading the questions or writing responses) at around the same time every quarter using the QCE-ACC Interviewer Facilitated Version.
 - c. Arrange proxy-completion for all care recipients who cannot complete the QCE-ACC through self-completion or interviewer facilitated completion (e.g. due to moderate or



severe cognitive impairment) at around the same time every quarter using the QCE-ACC Proxy Version.

2. Record the care recipients excluded because they were absent from the service for the entire quarter.
3. Record the care recipients excluded because they did not choose to complete the QCE-ACC for the entire quarter.

Note: Care recipients with no or mild cognitive impairment who chose not to complete the QCE-ACC by self-completion or interviewer facilitated completion are considered to have withheld consent. Where a care recipient requires a proxy (e.g. due to moderate or severe cognitive impairment) and either a suitable proxy cannot be identified or the proxy does not complete the QCE-ACC, a staff member at the service who knows the care recipient well may act as a proxy to complete the QCE-ACC.

4. Record the care recipients who reported consumer experience through each completion mode of the QCE-ACC (self-completion, interviewer facilitated completion or proxy-completion), scored against the five categories:
 - 'Excellent' (care recipients who score between 22–24)
 - 'Good' (care recipients who score between 19–21)
 - 'Moderate' (care recipients who score between 14–18)
 - 'Poor' (care recipients who score between 8–13)
 - 'Very poor' (care recipients who score between 0–7).

19.3.1 Inclusions for consumer experience

All care recipients must be assessed for consumer experience except for those listed in [19.3.2 Exclusions for consumer experience](#).

19.3.2 Exclusions for consumer experience

Care recipients who:

- were absent from the service for the entire quarter; or
- did not choose to complete the QCE-ACC for the entire quarter;

are excluded from assessment for consumer experience, but are reported under additional reporting requirements.





19.4 Data reporting for consumer experience

Pursuant to section 26(b) of the [Accountability Principles](#), approved providers must compile or otherwise derive information from these measurements and assessments that is relevant to indicating the quality of residential care. The information compiled or derived from the measurements and assessments must not be personal information (within the meaning of the *Privacy Act 1988*) about any of the care recipients.

Approved providers must compile or derive information in accordance with the requirements below. Approved providers must ensure that the information compiled or derived in accordance with these requirements does not contain personal information about any of the care recipients.



Table 27: REQUIREMENTS FOR DATA REPORTING ON CONSUMER EXPERIENCE

1	Number of care recipients offered a consumer experience assessment through self-completion, interviewer facilitated completion or proxy--completion. Note: All care recipients must be assessed for consumer experience except for those listed in 19.3.2 Exclusions for consumer experience.	
2	Number of care recipients excluded because they were absent from the service for the entire quarter.	
3	Number of care recipients excluded because they did not choose to complete the QCE-ACC for the entire quarter.	
4	Number of care recipients who reported consumer experience through each completion mode of the QCE-ACC (self-completion, interviewer facilitated completion, or proxy-completion), scored against the five categories: <ul style="list-style-type: none">• 'Excellent' (care recipients who score between 22–24)• 'Good' (care recipients who score between 19–21)• 'Moderate' (care recipients who score between 14–18)• 'Poor' (care recipients who score between 8–13)• 'Very poor' (care recipients who score between 0–7).	

19.5 How to report consumer experience

Pursuant to section 26(c) of the [Accountability Principles](#), approved providers must submit the quality indicator data into GPMS in order to make the information available to the Secretary.

19.6 Additional resources for consumer experience

More information and resources related to consumer experience are included in [Appendix C](#), and are available at www.health.gov.au and in QI Program Manual 4.0 - Part B.



20 Quality of life

20.1 Overview of quality of life

Quality of life refers to a person's perception of their position in life taking into consideration their environment and their goals, expectations, standards, and concerns. It includes their emotional, physical, material, and social wellbeing.

The Quality of Life Aged Care Consumers © *Flinders University 2022* (QOL-ACC)¹² tool was co-designed with older Australians to assess important aspects of quality of life. The QOL-ACC is comprised of six questions focused on six key attributes of quality of life — independence, mobility, pain management, emotional wellbeing, social relationships, and leisure activities/hobbies.


The QOL-ACC is the quality of life assessment tool used for the purposes of the QI Program, included in [Appendix D](#).

Approved providers of residential care services must collect and report on quality of life data quarterly, according to the requirements set out in this Manual.

¹² Cleland, J, Hutchinson, C, McBain, C, Walker, R, Milte, R, Khadka, J and Ratcliffe, J (2020), Developing dimensions for a preference-based quality of life instrument for older people receiving aged care services in the community, *Quality of Life Research*, p. 1–11.



Table 28: QUALITY OF LIFE QUALITY INDICATOR OVERVIEW

 <p>Percentage of care recipients who report 'good' or 'excellent' quality of life</p>	Collection <ul style="list-style-type: none">• A quality of life assessment must be offered to each care recipient for completion, around the same time every quarter
	Quality indicator reporting <ul style="list-style-type: none">• Care recipients who reported quality of life through each completion mode of the QOL-ACC (self-completion, interviewer facilitated completion and proxy-completion), scored against the categories:<ul style="list-style-type: none">○ 'Excellent' (care recipients who score between 22–24)○ 'Good' (care recipients who score between 19–21)
	Additional reporting <ul style="list-style-type: none">• Care recipients who were offered a quality of life assessment for completion• Care recipients who reported quality of life through each completion mode of the QOL-ACC (self-completion, interviewer facilitated completion and proxy-completion), scored against the categories:<ul style="list-style-type: none">○ 'Moderate' (care recipients who score between 14–18)○ 'Poor' (care recipients who score between 8–13)○ 'Very poor' (care recipients who score between 0–7)
	Exclusions <ul style="list-style-type: none">• Care recipients who were absent from the service for the entire quarter• Care recipients who did not choose to complete the quality of life assessment for the entire quarter

20.2 Key terms for quality of life

The Quality of Life Aged Care Consumers© (QOL-ACC) tool asks care recipients to indicate their quality of life by selecting the most appropriate statement using a five or six-point scale. This ranges from 'none of the time' to 'all of the time' for five survey questions, with the question about pain management having a 'not applicable' option, see [Appendix D](#).

The care recipient's scores for each of the six questions is added together to give a total score. The guidance provides a rescaling tool if a care recipient answers 'not applicable' to the pain management question. Once scored, these are then assigned to one of five categories describing overall quality of life:

- **Excellent** quality of life: where a care recipient scores between 22–24
- **Good** quality of life: where a care recipient scores between 19–21
- **Moderate** quality of life: where a care recipient scores between 14–18
- **Poor** quality of life: where a care recipient scores between 8–13
- **Very poor** quality of life: where a care recipient scores between 0–7.

Anonymous collection of QOL-ACC assessments is preferred and should be supported to the extent possible.



For the purposes of the QI Program, **self-completion** is when a care recipient independently completes the QOL-ACC Self-Complete Version. It is recommended the QOL-ACC is self-completed by all care recipients with capacity (e.g. care recipients with no or mild cognitive impairment). Approved providers are encouraged to facilitate anonymous, self-completion where possible, using the QOL-ACC Self-Complete Version.

Note: Where self-completion by a care recipient is not possible because they are unable to read the questions or write responses, interviewer facilitated completion is recommended (see below).

Note: Where self-completion and interviewer facilitated completion is not possible because a care recipient has moderate or severe cognitive impairment, proxy-completion is recommended (see below).

For the purposes of the QI Program, **interviewer facilitated completion** is when a care recipient requires additional support (e.g. support with reading the questions or writing responses) to facilitate completion using the QOL-ACC Interviewer Facilitated Version. The interviewer must not influence scoring by the care recipient and must use the QOL-ACC Interview Facilitated Version.

For the purposes of the QI Program, **proxy-completion** is when a care recipient is unable to answer on their own behalf (e.g. because of moderate or severe cognitive impairment), the QOL-ACC Proxy Version is used by a person who knows the care recipient well and sees them regularly (e.g. an informal carer, relative) to facilitate completion. The proxy respondent should answer based on their own knowledge of the care recipient and their quality of life at the time of administration using the QOL-ACC Proxy Version. It is only appropriate for a care worker or other employee at the service to act as proxy for the care recipient if a proxy with a more suitable relationship to the care recipient is unavailable.

20.3 Measurements and assessments for quality of life

The purpose of assessing a care recipient through the process set out below is to collect data relating to the quality of life quality indicator.

Pursuant to section 26(a) of the [Accountability Principles](#), approved providers must make assessments and measurements that are relevant to indicating the quality of residential care in accordance with the requirements listed below.

1.
 - a. Offer the QOL-ACC Self-Complete Version for self-completion to all suitable care recipients at the service at around the same time every quarter. The QOL-ACC Self-Complete Version can be self-completed by care recipients with no or mild cognitive impairment.
 - b. Arrange interviewer facilitated completion for all care recipients requiring assistance to complete the QOL-ACC (e.g. where the care recipient requires support with reading the questions or writing responses) at around the same time every quarter using the QOL-ACC Interviewer Facilitated Version.
 - c. Arrange proxy-completion for all care recipients who cannot complete the QOL-ACC through self-completion or interviewer facilitated completion (e.g. due to moderate or severe cognitive impairment) at around the same time every quarter using the QOL-ACC Proxy Version.



2. Record the care recipients excluded because they were absent from the service for the entire quarter.
3. Record the care recipients excluded because they did not choose to complete the QOL-ACC for the entire quarter.

Note: Care recipients with no or mild cognitive impairment who chose not to complete the QOL-ACC by self-completion or interviewer facilitated completion are considered to have withheld consent. Where a care recipient requires a proxy (e.g. due to moderate or severe cognitive impairment) and either a suitable proxy cannot be identified or the proxy does not complete the QOL-ACC, a staff member at the service who knows the care recipient well may act as a proxy to complete the QOL-ACC.

4. Record the care recipients who reported quality of life through each completion mode of the QOL-ACC (self-completion, interviewer facilitated completion or proxy-completion), scored against the five categories:
 - 'Excellent' (care recipients who score between 22–24)
 - 'Good' (care recipients who score between 19–21)
 - 'Moderate' (care recipients who score between 14–18)
 - 'Poor' (care recipients who score between 8–13)
 - 'Very poor' (care recipients who score between 0–7).

20.3.1 Inclusions for quality of life

All care recipients must be assessed for quality of life except for those listed [in 20.3.2 Exclusions for quality of life](#).

20.3.2 Exclusions for quality of life

Care recipients who:

- were absent from the service for the entire quarter; or
- did not choose to complete the QOL-ACC for the entire quarter;

are excluded from assessment for quality of life, but are reported under additional reporting requirements.





20.4 Data reporting for quality of life

Pursuant to section 26(b) of the [Accountability Principles](#), approved providers must compile or otherwise derive information from these measurements and assessments that is relevant to indicating the quality of residential care. The information compiled or derived from the measurements and assessments must not be personal information (within the meaning of the *Privacy Act 1988*) about any of the care recipients.

Approved providers must compile or derive information in accordance with the requirements below. Approved providers must ensure that the information compiled or derived in accordance with these requirements does not contain personal information about any of the care recipients.



Table 29: REQUIREMENTS FOR DATA REPORTING ON QUALITY OF LIFE

1	Number of care recipients offered a quality of life assessment through self-completion, interviewer facilitated completion or proxy--completion. Note: All care recipients must be assessed for quality of life except for those listed in 20.3.2 Exclusions for quality of life.	
2	Number of care recipients excluded because they were absent from the service for the entire quarter.	
3	Number of care recipients excluded because they did not choose to complete the QOL-ACC for the entire quarter.	
4	Number of care recipients who reported quality of life through each completion mode of the QOL-ACC (self-completion, interviewer facilitated completion or proxy-completion), scored against the five categories: <ul style="list-style-type: none">• 'Excellent' (care recipients who score between 22–24)• 'Good' (care recipients who score between 19–21)• 'Moderate' (care recipients who score between 14–18)• 'Poor' (care recipients who score between 8–13)• 'Very poor' (care recipients who score between 0–7).	

20.5 How to report quality of life

Pursuant to section 26(c) of the [Accountability Principles](#), approved providers must submit the quality indicator data into GPMS in order to make the information available to the Secretary.

20.6 Additional resources for quality of life

More information and resources related to quality of life are included in [Appendix D](#), and are available at www.health.gov.au and in QI Program Manual 4.0 - Part B



21 Enrolled nursing (EN): Proportion of EN care minutes


Nurses are essential health professionals who care for people in health and aged care settings. Nurses have the knowledge and skills to give high quality care where and when it is needed. Approved providers are to report the enrolled nursing (EN) quality indicator against:

1. Proportion of EN care minutes (this Section), and
2. Proportion of nursing care minutes (see Section 22 of this Manual)

Approved providers are not required to submit data through the QI Program app on GPMS for these data points. The Department will extract the data needed to calculate these from data submitted through the Quarterly Financial Report (QFR) (see table 31 for details). This will then be pulled across to the QI Program app in GPMS and enable approved providers to see their enrolled nursing data alongside their other QI Program data.

21.1 Overview of enrolled nursing: Proportion of EN care minutes

Table 30: ENROLLED NURSING QUALITY INDICATOR OVERVIEW

 Proportion of EN care minutes (EN care minutes as a percentage of total care minutes).	Collection <ul style="list-style-type: none">• The Department will calculate the 'proportion of EN care minutes' data point using data submitted by approved providers through the QFR
	Quality indicator reporting (pulled from QFR) <ul style="list-style-type: none">• EN care minutes per resident per day
	Additional reporting <ul style="list-style-type: none">• RN care minutes per resident per day• PCW/AIN care minutes per resident per day

AIN: assistant in nursing; EN: enrolled nurse; PWC: personal care worker; RN: registered nurse

21.2 Key terms for enrolled nursing: Proportion of EN care minutes

An EN is a health care professional who provides nursing care under the direct or indirect supervision of a RN. ENs complete a [Diploma of Nursing](#) through a vocational education approved provider, to meet the [EN standards for practice](#). ENs work under the supervision of a registered nurse and cannot act alone.

Registered nurses (RNs) complete a [3-year Bachelor of Nursing or 2-year Master of Nursing](#) through a university to meet the [RN standards for practice](#).



A personal care worker (PCW) is an employee classified under Schedule B.2 in the Aged Care Award 2010 as an Aged Care employee – direct care Level 2 to 7 (Grade 1 to 5 PCW), excluding aged care employee direct care Level 6. An approved provider may employ a PCW in an equivalent role in a corresponding award/enterprise agreement; or an individual contract/agreement.

An Assistant in Nursing (AIN) (or nursing assistant) is an employee classified under Schedule B.2.1 in the Nurses Award 2020. PCWs and AINs work under the supervision and guidance of a nurse (RN/EN).



The Government funds approved providers through Australian National Aged Care Classification (AN-ACC) to have a sufficient mix of RNs, ENs and PCWs/AINs on duty at all times. This is so approved providers can provide safe and quality care to residents living at their residential aged care services.

21.3 Data reporting for enrolled nursing (EN): Proportion of EN care minutes

Pursuant to Part 4A of the [Accountability Principles](#), an approved provider must, for each quarter of a financial year for the approved provider, give the Secretary a report (a quarterly financial report) for the approved provider for the quarter.

The department will extract data submitted through the QFR and undertake calculations to reach these data points as per below. Please see the [QFR webpage](#) for more information on the QFR requirements.

Table 31: REQUIREMENTS FOR DATA REPORTING ON ENROLLED NURSING

1	EN care minutes per resident per day.	
2	Total care minutes per resident per day¹. (EN care minutes per resident per day + RN care minutes per resident per day + PCW/AIN care minutes per resident per day)	

¹Care minute values are calculated as:

- EN care minutes per resident per day = (EN employee labour hours + EN agency hours) * 60 mins / Occupied bed days
- RN care minutes per resident per day = (RN employee labour hours + RN agency hours) * 60 mins / Occupied bed days
- PCW/AIN care minutes per resident per day = (PCW/AIN employee labour hours + PCW/AIN agency hours) * 60 mins / Occupied bed days



21.4 How to report enrolled nursing (EN): Proportion of EN care minutes

Approved providers are to report EN, RN and PCW/AIN labour hours as well as occupied bed days for each quarter as part of the QFR. These are used to work out the EN care minutes per resident per day and the total care minutes per resident per day. As QFR and QI reporting timeframes do not align, there may be a delay in QFR data extraction into the QI Program app in GPMS.

Approved providers must submit quality indicator data for all quality indicators excluding enrolled nursing, allied health care minutes and lifestyle officer into GPMS no later than the **21st day of the month after the end of each quarter**. The extracted and calculated EN indicator data from the QFR will display in GPMS only once the approved provider has completed their initial QFR submission.

21.5 Additional resources for enrolled nursing (EN): Proportion of EN care minutes

More information and resources for enrolled nursing are available at www.health.gov.au and in QI Program Manual 4.0 - Part B.



22 Enrolled nursing (EN): Proportion of nursing care minutes


Nurses are essential health care professionals who care for people in health and aged care settings. Nurses have the knowledge and skills to provide high quality care where and when care recipients need it. Approved providers are to report the enrolled nursing quality indicator against:

1. Proportion of EN care minutes (see Section 21 of this Manual), and
2. Proportion of nursing care minutes (this Section)

Approved providers are not required to submit data through QI Program reporting for each category. The Department will extract the data needed to calculate these data points from data submitted through the Quarterly Financial Report (QFR) (see table 33 for details) This will then be pulled across to the QI Program app in GPMS and enable approved providers to see their enrolled nursing data alongside their other QI Program data.

22.1 Overview of enrolled nursing (EN): Proportion of nursing care minutes

Table 32: ENROLLED NURSING - PROPORTION OF NURSING CARE MINUTES QUALITY INDICATOR OVERVIEW

 Proportion of nursing care minutes.	Collection
	<ul style="list-style-type: none">• The Department will calculate the 'proportion of nursing care minutes' data point using data the approved has submitted through the QFR
	Quality indicator reporting (pulled from QFR)
	<ul style="list-style-type: none">• Nursing care minutes per resident per day²
	Additional reporting
	<ul style="list-style-type: none">• PCW/AIN care minutes per resident per day

²Nursing care minutes is EN care minutes per resident per day + RN care minutes per resident per day.

22.2 Key terms for enrolled nursing (EN): Proportion of nursing care minutes

An EN is a health care professional who provides nursing care under the direct or indirect supervision of a RN. ENs complete a [Diploma of Nursing](#) through a vocational education approved provider, to meet the [EN standards for practice](#). ENs work under the supervision of a registered nurse and cannot act alone.

RNs complete a [3-year Bachelor of Nursing or 2-year Master of Nursing](#) through a university to meet the [RN standards for practice](#).

A personal care worker (PCW) is an employee classified under Schedule B.2 in the Aged Care Award 2025 as an Aged Care employee – direct care Level 2 to 7 (Grade 1 to 5 PCW), excluding aged care employee direct care Level 6. On the other hand, an approved provider may employ a



PCW in an equivalent role in a corresponding award/enterprise agreement; or an individual contract/agreement.

An Assistant in Nursing (AIN) (or nursing assistant) is an employee classified under Schedule B.2.1 in the Nurses Award 2020. PCWs and AINs work under the supervision and guidance of a nurse (RN/EN).

The Government funds approved providers through Australian National Aged Care Classification (AN-ACC) to have a sufficient mix of RNs, ENs and PCWs/AINs on duty at all times. This is so approved providers can provide safe and quality care to care recipients living at their residential aged care services.



For the purposes of the QI Program 'nursing care minutes' refers to EN care minutes per resident per day + RN care minutes per resident per day.

22.3 Data reporting for enrolled nursing (EN): Proportion of nursing care minutes

Under Part 4A of the [Accountability Principles](#), an approved provider must, for each quarter of a financial year approved provider, give the Secretary a report (a quarterly financial report) for the approved provider for the quarter.

Approved providers are not required to submit data through QI Program reporting for each category. The Department will extract the data needed to calculate these data points from data submitted through the Quarterly Financial Report (QFR) (see table 33 for details). Please see the [QFR webpage](#) for more information on the QFR requirements.

Table 33: REQUIREMENTS FOR DATA REPORTING ON ENROLLED NURSING

1	Nursing care minutes per resident per day (EN care minutes per resident per day + RN care minutes per resident per day)	
2	Total care minutes per resident per day¹. (EN care minutes per resident per day + RN care minutes per resident per day + PCW/AIN care minutes per resident per day)	

¹Care minute values are calculated as:

- EN care minutes per resident per day = (EN employee labour hours + EN agency labour hours) * 60 mins / Occupied bed days
- RN care minutes per resident per day = (RN employee labour hours + RN agency labour hours) * 60 mins / Occupied bed days
- PCW/AIN care minutes per resident per day = (PCW/AIN employee labour hours + PCW/AIN agency labour hours) * 60 mins / Occupied bed days



22.4 How to report enrolled nursing (EN): Proportion of nursing care minutes

Approved providers are to report EN, RN and PCW/AIN labour hours as well as occupied bed days for the quarter as part of the QFR. These are used to work out the EN care minutes per resident per day, RN care minutes per resident per day and the total care minutes per resident per day. As QFR and QI reporting timeframes do not align, there may be a delay in QFR data extraction into the QI Program app in GPMS. Approved providers must submit quality indicator data for all quality indicators excluding enrolled nursing, allied health care minutes and lifestyle officer into GPMS no later than the 21st day of the month after the end of each quarter. The extracted and calculated EN indicator data from the QFR will display in GPMS only once the approved provider has completed their initial QFR submission.

22.5 Additional resources for enrolled nursing (EN): proportion of nursing care minutes

More information and resources for enrolled nursing are available at www.health.gov.au and in QI Program Manual 4.0 - Part B.



23 Allied health: Allied health care minutes

Allied health services are critical to providing quality care to meet the needs of older Australians residing in residential aged care.

Allied health professionals are health professionals that are not part of the medical, dental, pharmacy or nursing professions. They are university qualified practitioners with specialised expertise in preventing, diagnosing and treating a range of conditions and illnesses.

Approved providers of residential aged care must make a range of allied health services available to care recipients under Schedule 1 of the *Quality of Care Principles 2014*. This includes access to allied health services as part of an individual therapy program aimed at maintaining or restoring a care recipient's ability to perform daily tasks.

In addition, under the Aged Care Quality Standards (Quality Standards) approved providers must ensure each care recipient receives safe and effective personal care and clinical care. This includes ongoing assessment and planning for care and providing timely and appropriate referrals to individuals, other organisations and approved providers of other care and services.


23.1 Overview of allied health care minutes

Approved providers are to report the allied health quality indicator against:

1. Allied health care minutes (see this Section).
2. Percentage of recommended allied health services received (see [Section 24](#) of this Manual).

Approved providers are not required to submit data through QI Program reporting for the allied health care minutes data point. The Department will extract the data needed to calculate these data points from data submitted through the QFR (see table 35 for details). This will then be pulled across to the QI Program app in GPMS and enable approved providers to see their allied health care minutes data alongside their other QI Program data.

Table 34: ALLIED HEALTH QUALITY INDICATOR OVERVIEW

 Allied health care minutes.	Collection <ul style="list-style-type: none">• The Department will calculate the 'allied health care minutes' data point using data submitted by approved providers through the QFR
	Quality indicator reporting (pulled from QFR) <ul style="list-style-type: none">• Allied health care minutes per resident per day
	Additional reporting <ul style="list-style-type: none">• Physiotherapy care minutes per resident per day• Occupational care minutes per resident per day• Speech pathology care minutes per resident per day• Podiatry care minutes per resident per day• Dietetics care minutes per resident per day• Other care minutes per resident per day• Allied health assistant care minutes per resident per day



23.2 Key terms for allied health care minutes

For the purposes of the QI Program, allied health services are defined in line with the QFR:

- physiotherapy
- occupational therapy
- speech pathology
- podiatry
- dietetics
- other allied health²
- allied health assistant.

²Other allied health includes the following disciplines and is defined in line with the QFR:



- art therapists
- audiologists
- chiropractors
- counsellors
- diabetes educators
- exercise physiologists
- music therapists
- osteopaths
- psychologists
- social workers

23.3 Data reporting for allied health care minutes

Under Part 4A of the [Accountability Principles](#), an approved provider must, for each quarter of a financial year, give the Secretary a report (a quarterly financial report) for the approved provider for the quarter.

The Department will extract the data needed to calculate these data points from data submitted through the QFR (see table 35 for details). Please see the [QFR webpage](#) for more information on the QFR requirements.

Table 35: REQUIREMENTS FOR DATA REPORTING ON ALLIED HEALTH CARE MINUTES

1	Allied health care minutes per resident per day (Allied health employee labour hours *60 + allied health agency labour hours*60) / Occupied bed days	
2	Physiotherapy care minutes per resident per day (Physiotherapist employee labour hours*60 + Physiotherapist agency staff labour hours*60) / Occupied bed days.	
3	Occupational therapy care minutes per resident per day (Occupational Therapist employee labour hours*60 + Occupational Therapist agency labour hours*60) / Occupied bed days.	
4	Speech pathology care minutes per resident per day (Speech Pathologist employee labour hours*60 + Speech Pathologist agency labour hours*60) / Occupied bed days.	



5	Podiatry care minutes per resident per day (Podiatrist labour hours*60 + Podiatrist agency labour hours*60) / Occupied bed days.	
6	Dietetics care minutes per resident per day (Dietetic Care labour hours*60 + Dietetic Care agency labour hours*60) / Occupied bed days.	
7	Other allied health care minutes per resident per day (Other allied health employee labour hours*60 + Other allied health agency labour hours*60) / Occupied bed days.	
8	Allied health assistant care minutes per resident per day (Allied Health Assistants employee labour hours*60 + Allied Health Assistants agency labour hours*60) / Occupied bed days.	

23.4 How to report allied health care minutes

Approved providers are to report allied health labour hours and occupied bed days for the quarter as part of the QFR. These are used to work out the allied health care minutes per resident per day. As QFR and QI reporting timeframes do not align, there may be a delay in QFR data extraction into the QI Program app in GPMS.

Approved providers must submit quality indicator data for all quality indicators excluding enrolled nursing, allied health care minutes and lifestyle officer into GPMS no later than **the 21st day of the month after the end of each quarter**. The extracted and calculated allied health data from the QFR will display in GPMS only once the approved provider has completed their initial QFR submission.

23.5 Additional resources for allied health care minutes

More information and resources for allied health are available at www.health.gov.au and in QI Program Manual 4.0 – Part B.



24 Allied health: recommended services received

Allied health services are critical to providing quality care to meet the needs of older Australians.

Allied health professionals are health professionals that are not part of the medical, dental, pharmacy or nursing professions. They are university qualified practitioners with specialised expertise in preventing, diagnosing and treating a range of conditions and illnesses.

Approved providers of residential aged care must make a range of allied health services available to care recipients under Schedule 1 of the *Quality of Care Principles 2014*. This includes access to allied health services as part of an individual therapy program aimed at maintaining or restoring a care recipient's ability to perform daily tasks.

In addition, under the Aged Care Quality Standards (Quality Standards) approved providers must ensure each care recipient receives safe and effective personal care and clinical care. This includes ongoing assessment and planning for care and providing timely and appropriate referrals to individuals, other organisations and approved providers of other care and services.

24.1 Overview of allied health - recommended services received

Approved providers are to report the allied health quality indicator against:

1. Allied health care minutes (see [Section 23](#) of the Manual).
2. Percentage of recommended allied health services received (see this Section).



Table 36: allied health quality indicator overview

 Percentage of recommended allied health services received.	Collection <ul style="list-style-type: none">• A single review of care records for each care recipient. The review must be after the end of the current quarter before data is due (the 21st day of the month after the quarter ended).
	Quality indicator reporting <ul style="list-style-type: none">• number of allied health services recommended in care plans• number of recommended allied health services received
	Additional reporting <ul style="list-style-type: none">• number of care recipients assessed for allied health• number of care recipients excluded because they were absent from the service for the entire quarter• number of allied health services recommended in care plans against:<ul style="list-style-type: none">○ physiotherapy○ occupational therapy○ speech pathology○ podiatry○ dietetics○ other allied health³○ allied health assistant.• number of recommended allied health services received against each discipline.<ul style="list-style-type: none">○ physiotherapy○ occupational therapy○ speech pathology○ podiatry○ dietetics○ other allied health³○ allied health assistant.

24.2 Key terms for allied health - recommended services received

For the purposes of the QI Program, allied health services are defined in line with the QFR:

- physiotherapy
- occupational therapy
- speech pathology
- podiatry
- dietetics
- other allied health³
- allied health assistant

³Other allied health includes the following disciplines and is defined in line with the QFR:

- art therapists
- audiologists
- chiropractors
- counsellors



- diabetes educators
- exercise physiologists
- music therapists
- osteopaths
- psychologists
- social workers

24.3 Measurements and assessments for allied health - recommended services received

The purpose of assessing a care recipient through the process set out below is to collect data for the allied health - recommended services received data point.

Under section 26(a) of the [Accountability Principles](#), approved providers must make assessments and measurements that are relevant to indicating the quality of residential care in accordance with the requirements listed below.

1. Record the care recipients whose care plans are assessed for an allied health recommendation
2. Record the care recipients excluded because they were absent from the service for the entire quarter.
3. Review and record each care recipient's care plans and assess whether each care recipient had a recommendation for an allied health service and the allied health discipline that the recommendation was for.

Note: You only need to report once per discipline. For example, if the care recipient has three dietetic appointments and one physiotherapy recommendation this should be counted as two recommendations: one for dietetics, one for physiotherapy.

4. For care recipients who had a recommendation for an allied health service during the assessment period recorded in step 4, record whether they received that allied health service by discipline.

Note: You only need to report services received that were recommended. For example, if the care recipient has a recommendation for dietetic and physiotherapy, and they receive an appointment with a dietitian and a speech pathologist, you would report this as one recommended dietetic allied health service received.

24.3.1 Inclusions for allied health - recommended services received

All care recipients must be assessed for allied health- recommended services received except those listed in [24.3.2. Exclusions for allied health - recommended services received](#).

24.3.2 Exclusions for allied health - recommended services received

Care recipients who were absent from the service for the entire quarter, are excluded from assessment for allied health – recommended services received but are reported under 'additional reporting requirements'.

24.3.3 Data reporting for allied health - recommended services received

Pursuant to section 26(b) of the [Accountability Principles](#), approved providers must compile or otherwise derive information from these measurements and assessments that is relevant to indicating the quality of residential care. The information compiled or derived from the





measurements and assessments must not be personal information (within the meaning of the *Privacy Act 1988*) about any of the care recipients.)

TABLE 37: REQUIREMENTS FOR DATA REPORTING ON ALLIED HEALTH – RECOMMENDED SERVICES RECEIVED

1	Number of care recipients assessed for allied health.	
2	Number of care recipients excluded because they were absent from the service for the entire quarter.	
3	Number of allied health services recommended in care plans.	
4	Number of physiotherapy services recommended in care plans.	
5	Number of occupational therapy services recommended in care plans.	
6	Number of speech pathology services recommended in care plans.	
7	Number of podiatry services recommended in care plans.	
8	Number of dietetic services recommended in care plans.	
9	Number of other allied health services recommended in care plans.	
10	Number of allied health assistant services recommended in care plans.	
11	Number of recommended allied health services received.	
12	Number of recommended physiotherapy allied health services received.	
13	Number of recommended occupational therapy services received.	
14	Number of recommended speech pathology services received.	
15	Number of recommended podiatry services received.	
16	Number of recommended dietetic services received.	



17	Number of recommended other services received.	
18	Number of recommended allied health assistant services received.	

Note: The approved provider only needs to report once per discipline per resident. For example, in a care recipient's care plan, three dietetic appointments were recommended and one physiotherapy recommended, this will be counted as two recommendations: one for dietetics, one for physiotherapy.

24.4 How to report allied health - recommended services received

Pursuant to section 26(c) of the [Accountability Principles](#), approved providers must submit the quality indicator data into GPMS to make the information available to the Secretary.

24.5 Additional resources for allied health - recommended services received

More information and resources for allied health – recommended services received are available at www.health.gov.au and in QI Program Manual 4.0 - Part B.



25 Lifestyle officer

Lifestyle officers or lifestyle assistants typically provide support to care recipients to do activities to enhance their psychological, spiritual, social and physical well-being.

25.1 Overview of lifestyle officer


Approved providers of residential aged care are required to report the labour costs of Diversional / Lifestyle / Recreation / Activities officers as part of the QFR.

Approved providers are to report the lifestyle officer quality indicator against:

- Lifestyle officer care minutes

Approved providers are not required to submit data through QI Program reporting for the lifestyle officer care minutes data point. The Department will extract the data needed to calculate these data points from data submitted through the QFR (see table 38 for details) This will then be pulled across to the QI Program app in GPMS and enable approved providers to see their lifestyle care minutes data alongside their other QI Program data.

Table 38: LIFESTYLE OFFICER QUALITY INDICATOR OVERVIEW

 Lifestyle officer care minutes.	Collection <ul style="list-style-type: none">• The Department will calculate lifestyle officer care minutes for the purposes of the QI Program from data submitted by approved providers through the QFR.
	Quality indicator reporting (pulled from QFR) <ul style="list-style-type: none">• Lifestyle officer care minutes

25.2 Key terms for lifestyle officer

Only Diversional / Lifestyle / Recreation / Activities officer hours relating to caring for government subsidised residential aged care recipients (including those receiving residential respite) funded under the Australian National Aged Care Classification A(AN-ACC) model should be included. Total hours worked not including leave and training hours. Where Diversional / Lifestyle / Recreation / Activities officers are employed in hybrid roles, their time should be split/apportioned based on the times allocated to each role. Where Diversional / Lifestyle / Recreation / Activities officers work across separate residential aged care services, time should be split/apportioned based on the time allocated to each service.

For the purposes of the QI Program, the lifestyle officer quality indicator will use 'Diversional / Lifestyle / Recreation / Activities officer residential labour hours' data submitted through the QFR.


25.3 Data reporting for lifestyle officer

Pursuant to Part 4A of the [Accountability Principles](#), an approved provider must, for each quarter of a financial year for the approved provider, give the Secretary a report (a quarterly financial report) for the approved provider for the quarter.



Approved providers are not required to submit data through QI Program reporting for this data point. The Department will extract the data needed to calculate these data points from data submitted through the QFR (see table 39 for details). Please see the [QFR webpage](#) for further information on the QFR requirements.

Table 39: REQUIREMENTS FOR DATA REPORTING ON LIFESTYLE OFFICER

1	Lifestyle officer care minutes per resident per day⁴ (Diversional / Lifestyle / Recreation / Activities officer employee labour hours*60 + Diversional / Lifestyle / Recreation / Activities Officer agency hours*60)/ occupied bed days	
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⁴Lifestyle officer care minutes is calculated by - (Diversional / Lifestyle / Recreation / Activities officer employee labour hours*60 + Diversional / Lifestyle / Recreation / Activities Officer agency hours*60)/ occupied bed days

25.4 How to report for lifestyle officer

Approved providers are to report Diversional / Lifestyle / Recreation / Activities officer (employee and agency) labour hours as well as occupied bed days for the quarter as part of the QFR. These are used to work out the lifestyle officer care minutes per resident per day. As QFR and QI reporting timeframes do not align, there may be a delay in QFR data extraction into the QI Program app in GPMS. Approved providers must submit quality indicator data for all quality indicators excluding enrolled nursing, allied health care minutes and lifestyle officer into GPMS no later than the **21st day of the month after the end of each quarter**. The extracted and calculated lifestyle officer data from the QFR will display in GPMS only once the approved provider has completed their initial QFR submission.

25.5 Additional resources for lifestyle officer

More resources for the lifestyle officer quality indicator are available at in QI Program Manual 4.0 – Part B.

Appendix A

Barthel Index of Activities of Daily Living

Barthel Index of Activities of Daily Living is a clinical rating scale containing 10 activities of daily living items, looking at personal or self care and mobility¹³. The items cover bowel and bladder continence, personal care, toileting, feeding, transfers, mobility, dressing, going up and down stairs and bathing.

Instructions¹⁴

Barthel Index of Activities of Daily Living scoring is based on a care recipient's performance or what a care recipient does, **not** as a record of a care recipient's capacity or what a care recipient could do.

A care recipient's performance is established using the best available evidence. This can include using existing knowledge of the care recipient obtained through routine personal care, asking the care recipient, referring to care records or by direct observation. Direct testing is not required.

Scoring is based on performance over the previous 24–48 hours, noting longer periods will be relevant for some items (e.g. bowel and bladder).

Scores range from 0 to 1, 2 or 3 for each activity.

Total possible scores range from 0–20, with lower scores indicating increased disability (a score less than 4 indicates total dependence).

The main aim is to establish the degree of independence from any help, physical or verbal, however minor and for whatever reason.

The need for supervision, prompting, or any external support renders the care recipient not independent.

Middle categories imply that the patient supplies over 50% of the effort.

The use of aids to be independent is allowed, provided the patient uses them independently.

¹³ Mahoney F and Barthel DW (1965), Functional evaluation: the Barthel Index, *Maryland State Medical Journal*, vol. 14, p. 61–65.

¹⁴ Wade DT and Collin C (1988), The Barthel ADL Index: a standard measure of physical disability, *International Disability Studies*, vol. 10(2), p.64–67.

Choose the statement that most closely corresponds to the care recipient's performance for each of the following 10 items. Record what a care recipient does, not what a care recipient could do.

A care recipient's performance is established using the best available evidence. This can include using existing knowledge of the care recipient obtained through routine personal care, asking the care recipient, referring to care records or by direct observation. Direct testing is not required.

Bowels	Score
0. Incontinent (or needs to be given enemata)	
1. Occasional accident (once per week)	
2. Continent	
Bladder	
0. Incontinent, or catheterised and unable to manage	
1. Occasional accident (max once per 24 hours)	
2. Continent (for over 7 days)	
Grooming	
0. Needs help with personal care	
1. Independent face / hair/ teeth / shaving (implements provided)	
Toilet use	
0. Dependent	
1. Needs some help, but can do something alone	
2. Independent (on and off, dressing, wiping)	
Feeding	
0. Unable	
1. Needs help cutting, spreading butter, etc.	
2. Independent (food provided within reach)	

Transfer	Score
0. Unable – no sitting balance	
1. Major help (one or two people, physical), can sit	
2. Minor help (verbal or physical)	
3. Independent	
Mobility	
0. Immobile	
1. Wheelchair independent, including corners, etc.	
2. Walks with help of one person (verbal or physical)	
3. Independent (but may use aid e.g. walking stick)	
Dressing	
0. Dependent	
1. Minor help, but can do about half unaided	
2. Independent (including buttons, zips, laces, etc.)	
Stairs	
0. Unable	
1. Needs help (verbal, physical, carrying aid)	
2. Independent up and down	
Bathing	
0. Dependent	
1. Independent (as in showers)	

Scoring:

Sum the patient's scores for each item. Total possible scores range from 0–20, with lower scores indicating increased disability.

ID: _____ Last Name: _____ DOB: / / Date completed: / /

Collin C, Wade DT, Davies S, Horne V (1988), The Barthel ADL Index: a reliability study, International Disability Studies, vol. 10(2) p. 61–63.



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Appendix B

GLOBIAD

Ghent Global IAD Categorisation Tool

THE GHENT GLOBAL IAD CATEGORISATION TOOL

Version 1.0 June



www.skintghent.com



PREFACE

Incontinence-associated dermatitis (IAD) is a specific type of irritant contact dermatitis characterized by erythema and oedema of the peri-anal or genital skin. In some cases, IAD is accompanied by bullae, erosion or secondary cutaneous infection (Gray et al., 2012). The aetiology of IAD is complex and multifactorial (Beeckman et al., 2009). Excessive skin surface moisture resulting in skin maceration, chemical, and physical irritation enhances the permeability of the skin compromising the skin barrier function (Mugita et al., 2015).

IAD prevalence and incidence figures vary by type of setting and populations. The prevalence of IAD is estimated between 5.7 and 22.8%, and the incidence of IAD between 3.4 and 50% (Gray et al., 2012). These differences may be explained by the lack of internationally agreed diagnostic criteria and the potential confusion with superficial pressure ulcers or other skin conditions (Beeckman et al., 2007). A recent Cochrane review revealed a substantial heterogeneity of reported outcomes and instruments in IAD research (Beeckman et al., 2016).

We are pleased to introduce the Ghent Global IAD Categorisation tool (GLOBIAD). The tool is the result of a two-year project involving 22 international experts and 823 clinicians from 30 countries. The GLOBIAD categorises IAD severity based on visual inspection of the affected skin areas. It aims to create an internationally agreed description of IAD severity, and to standardize the documentation of this condition in clinical practice and research.

The GLOBIAD is now available for introduction in clinical practice. We welcome any feedback and translations of the GLOBIAD in languages other than English. Please contact us via SKINT@UGent.be.

Kind regards

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Category 1: Persistent redness

1A - Persistent redness without clinical signs of infection



Critical criterion

- Persistent redness
A variety of tones of redness may be present. Patients with darker skin tones, the skin may be paler or darker than normal, or purple in colour.

Additional criteria

- Marked areas or discolouration from a previous (healed) skin defect
- Shiny appearance of the skin
- Macerated skin
- Intact vesicles and/or bullae
- Skin may feel tense or swollen at palpation
- Burning, tingling, itching or pain

1B - Persistent redness with clinical signs of infection



Critical criteria

- Persistent redness
A variety of tones of redness may be present. Patients with darker skin tones, the skin may be paler or darker than normal, or purple in colour.

Signs of infection

Such as white scaling of the skin (suggesting a fungal infection) or satellite lesions (pustules surrounding the lesion, suggesting a Candida albicans fungal infection).

Additional criteria

- Marked areas or discolouration from a previous (healed) skin defect
- Shiny appearance of the skin
- Macerated skin
- Intact vesicles and/or bullae
- The skin may feel tense or swollen at palpation
- Burning, tingling, itching or pain

Category 2: Skin loss

2A - Skin loss without clinical signs of infection



Critical criterion

- Skin loss
Skin loss may present as skin erosion (may result from damaged/eroded vesicles or bullae), denudation or excoriation. The skin damage pattern may be diffuse.

Additional criteria Persistent redness

A variety of tones of redness may be present. Patients with darker skin tones, the skin may be paler or darker than normal, or purple in colour

- Marked areas or discolouration from a previous (healed) skin defect
- Shiny appearance of the skin
- Macerated skin
- Intact vesicles and/or bullae
- Skin may feel tense or swollen at palpation
- Burning, tingling, itching or pain

2B - Skin loss with clinical signs of infection



Critical criteria

- Skin loss
Skin loss may present as skin erosion (may result from damaged/eroded vesicles or bullae), denudation or excoriation. The skin damage pattern may be diffuse.

- Signs of infection

Such as white scaling of the skin (suggesting a fungal infection) or satellite lesions (pustules surrounding the lesion, suggesting a Candida albicans fungal infection), slough visible in the wound bed (yellow/brown/greyish), green appearance within the wound bed (suggesting a bacterial infection with Pseudomonas aeruginosa), excessive exudate levels, purulent exudate (pus) or a shiny appearance of the wound bed.

Additional criteria

- Persistent redness
- Marked areas or discolouration from a previous (healed) skin defect
- Shiny appearance of the skin
- Macerated skin
- Intact vesicles and/or bullae
- Skin may feel tense or swollen at palpation
- Burning, tingling, itching or pain

Beeckman D, Van den Bussche K, Alves P, Beele H, Ciprandi G, Coyer F, de Groot T, De Meyer D, Dunk AM, Fourie A, García-Molina P, Gray M, Iblasi A, Jelnes R, Johansen E, Karadağ A, LeBlanc K, Kis Dadara Z, Long MA, Meaume S, Pokorna A, Romanelli M, Ruppert S, Schoonhoven L, Smet S, Smith C, Steininger A, Stockmayr M, Van Damme N, Voegeli D, Van Hecke A, Verhaeghe S, Woo K & Kottner J. The Ghent Global IAD Categorisation Tool (GLOBIAD). Skin Integrity Research Group- Ghent University 2017.

The categories do not necessarily relate to the natural history of IAD and are not intended to suggest how IAD may develop or progress. This categorisation tool may prove useful in the monitoring of IAD prevalence and incidence, and for research purposes.

CATEGORY 1: PERSISTENT REDNESS

Category 1A: Persistent redness without clinical signs of infection

Critical criterion

Persistent redness

A variety of tones of redness may be present. Patients with darker skin tones, the skin may be paler or darker than normal, or purple in colour.

Additional criteria

- Marked areas or discolouration from a previous (healed) skin defect
- Shiny appearance of the skin
- Macerated skin
- Intact vesicles and/or bullae
- Skin may feel tense or swollen at palpation
- Burning, tingling, itching or pain



Category 1B: Persistent redness with clinical signs of infection

Critical criteria

Persistent redness

A variety of tones of redness may be present. Patients with darker skin tones, the skin may be paler or darker than normal, or purple in colour.

Signs of infection

Such as white scaling of the skin (suggesting a fungal infection) or satellite lesions (pustules surrounding the lesion, suggesting a *Candida albicans* fungal infection).

Additional criteria

- Marked areas or discolouration from a previous (healed) skin defect
- Shiny appearance of the skin
- Macerated skin
- Intact vesicles and/or bullae
- Skin may feel tense or swollen at palpation
- Burning, tingling, itching or pain



CATEGORY 2: SKIN LOSS

Category 2A: Skin loss without clinical signs of infection

Critical criterion

Skin loss

Skin loss may present as skin erosion (may result from damaged/eroded vesicles or bullae), denudation or excoriation. The skin damage pattern may be diffuse.

Additional criteria

- Persistent redness
A variety of tones of redness may be present. Patients with darker skin tones, the skin may be paler or darker than normal, or purple in colour
- Marked areas or discolouration from a previous (healed) skin defect
- Shiny appearance of the skin
- Macerated skin
- Intact vesicles and/or bullae
- Skin may feel tense or swollen at palpation
- Burning, tingling, itching or pain



Category 2B: Skin loss with clinical signs of infection

Critical criteria

Skin loss

Skin loss may present as skin erosion (may result from damaged/eroded vesicles or bullae), denudation or excoriation. The skin damage pattern may be diffuse.

Signs of infection

Such as white scaling of the skin (suggesting a fungal infection) or satellite lesions (pustules surrounding the lesion, suggesting a *Candida albicans* fungal infection), slough visible in the wound bed (yellow/brown/greyish), green appearance within the wound bed (suggesting a bacterial infection with *Pseudomonas aeruginosa*), excessive exudate levels, purulent exudate (pus) or a shiny appearance of the wound bed.

Additional criteria

- Persistent redness
A variety of tones of redness may be present. Patients with darker skin tones, the skin may be paler or darker than normal, or purple in colour
- Marked areas or discolouration from a previous (healed) skin defect
- Shiny appearance of the skin
- Macerated skin
- Intact vesicles and/or bullae
- Skin may feel tense or swollen at palpation
- Burning, tingling, itching or pain



GLOSSARY

Bulla A circumscribed lesion > 1 cm in diameter that contains liquid (clear, serous or haemorrhagic), a large blister

Erosion Loss of either a portion of or the entire epidermis

Excoriation A loss of the epidermis and a portion of the dermis due to scratching or an exogenous injury

Maceration An appearance or surface softening due to constant wetting - frequently white

Papule An elevated, solid, palpable lesion that is ≤ 1 cm in diameter

Pustule A circumscribed lesion that contains pus

Scale A visible accumulation of keratin, forming a flat plate or flake

Swelling Enlargement due to accumulation of oedema or fluid, including blood

Vesicle A circumscribed lesion ≤ 1 cm in diameter that contains liquid (clear, serous or haemorrhagic), a small blister

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Appendix C



Quality of Care Experience Aged Care Consumers

QCE-ACC User Guide:
Information on how to use the QCE-ACC instrument

Quality of Care Experience – Aged Care Consumers:
A new instrument for measuring
quality of care experience in aged care

Version 3.0

November 2024



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For further information [visit the website](http://www.qol-acc.org) (www.qol-acc.org) or [email the QOL-ACC/QCE-ACC Team](mailto:caringfutures@flinders.edu.au) (caringfutures@flinders.edu.au).

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Introduction

This guide has been developed to provide users with background information and basic guidance for using the Quality of Care Experience-Aged Care Consumers instrument (QCE-ACC). It provides information on the administration of the instrument, general principles, terms of use, definitions and references relating to the QCE-ACC instrument and information about how to present the results.

What is the QCE-ACC?

The QCE-ACC can be used to measure the quality of care experience of people accessing aged care services in the community and in residential aged care.

The QCE-ACC is comprised of six questions focused on the following six key attributes of quality of care experience:

- (i) Respect and dignity
- (ii) Supported decision-making
- (iii) Skills of aged care staff
- (iv) Impact on health and well-being
- (v) Social relationships and community connection
- (vi) Confidence in lodging complaints



Respondents are asked to rate each aspect of quality of care experience on a five-point scale from 'always' to 'never'.

The respondent is asked to indicate his/her quality of care experience by ticking the box against the most appropriate statement in each of the six questions to describe their current quality of care experience. This information can then be used as a quantitative measure of quality of care experience for the individual respondents.

How was the QCE-ACC Developed?

The QCE-ACC instrument was developed from an extensive review of Australian and international literature to identify salient aspects of the aged care experience most important for older people. This review resulted in the identification of six key quality of care experience dimensions from which suitable questions were developed and piloted with older people. The QCE-ACC was then validated in two studies undertaken with over 1500 older people and family carers received aged care services in the community and in residential aged care. The QCE-ACC has a summary scoring system (see 'how to score the QCE-ACC' for more information).



How can the QCE-ACC be used?

Scope

Quality of care experience is an important outcome and a key quality indicator in aged care. The QCE-ACC is a new instrument designed specifically to capture information about the quality of care experience of older people receiving aged care services and supports, either in their own homes or in a residential care facility.

The QCE-ACC is suitable for application in quality assessment and along with our complementary Quality of Life – Aged Care Consumers (QOL-ACC) instrument which can be included in broader-based quality assessments by aged care providers.

The QCE-ACC can be self-completed by older people with no or mild cognitive impairment. A proxy version of the QCE-ACC is available and can be used with an informal carer who knows the resident well (such as a family member who visits regularly), where the older person is unable to answer on their own behalf. Ideally the proxy assessor should answer based on their own knowledge of the resident and their quality of care experience at the time that the QCE-ACC is administered. It is not appropriate for a care worker or other employee of the organisation to act as proxy for the older person in relation to the QCE-ACC.

Accessing the QCE-ACC

By using the QCE-ACC you are agreeing not to alter the instrument wording, content and presentation in any way without permission from the development team. Where the QCE-ACC instrument is being used for research, this document and/or the research publications emanating from the QCE-ACC project should be appropriately referenced. Where the QCE-ACC instrument is being used by residential aged care providers for the purposes beyond quality indicator reporting e.g. for research purposes, this user guide (see 'suggested citation') and/or the research publications emanating from the QCE-ACC project (see 'QCE-ACC publications') should be appropriately referenced.

Versions of the QCE-ACC

Several versions of the QCE-ACC are available including:

- Self-completion
- Proxy-completion
- Interviewer facilitated completion



Scoring the QCE-ACC

The QCE-ACC should be scored as follows:

For each question, please mark the ONE box that best describes how you feel about your current situation.

Date of completion ____/____/____

<p>1. I am treated with respect and dignity:</p> <p><input type="checkbox"/> Always</p> <p><input type="checkbox"/> Mostly</p> <p><input type="checkbox"/> Sometimes</p> <p><input type="checkbox"/> Rarely</p> <p><input type="checkbox"/> Never</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>This relates to how staff speak to you and respect your wishes, privacy, and belongings.</p> </div>	<p>4. I receive services and supports for daily living that are important for my health and wellbeing:</p> <p><input type="checkbox"/> Always</p> <p><input type="checkbox"/> Mostly</p> <p><input type="checkbox"/> Sometimes</p> <p><input type="checkbox"/> Rarely</p> <p><input type="checkbox"/> Never</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>This might include support for your physical health or your mental wellbeing, e.g. support to attend appointments, equipment to help you do daily tasks, assistance with taking medications.</p> </div>
<p>2. I am supported to make my own decisions about the care and services I receive:</p> <p><input type="checkbox"/> Always</p> <p><input type="checkbox"/> Mostly</p> <p><input type="checkbox"/> Sometimes</p> <p><input type="checkbox"/> Rarely</p> <p><input type="checkbox"/> Never</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>This relates to being able to make choices about the care you receive, e.g. choices related to care, food, and how you organise your day.</p> </div>	<p>5. I am supported to maintain my social relationships and connections with the community:</p> <p><input type="checkbox"/> Always</p> <p><input type="checkbox"/> Mostly</p> <p><input type="checkbox"/> Sometimes</p> <p><input type="checkbox"/> Rarely</p> <p><input type="checkbox"/> Never</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>You can consider your relationships or friendships with fellow residents, staff, volunteers, family or community inside or outside of the residential care home.</p> </div>
<p>3. I receive care and support from aged care staff who have the appropriate skills and training:</p> <p><input type="checkbox"/> Always</p> <p><input type="checkbox"/> Mostly</p> <p><input type="checkbox"/> Sometimes</p> <p><input type="checkbox"/> Rarely</p> <p><input type="checkbox"/> Never</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>This relates to how confident you feel that staff are able to provide quality care, e.g. administering medication safely, managing health conditions.</p> </div>	<p>6. I am comfortable lodging complaints with confidence that the appropriate action will be taken:</p> <p><input type="checkbox"/> Always</p> <p><input type="checkbox"/> Mostly</p> <p><input type="checkbox"/> Sometimes</p> <p><input type="checkbox"/> Rarely</p> <p><input type="checkbox"/> Never</p> <p><input type="checkbox"/> Not applicable</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>This relates to feeling comfortable to lodge a complaint with your provider, if needed, and feeling that your concerns will be taken seriously.</p> </div>

Perceived quality of care experience levels are scored as:

- Always = 4
- Mostly = 3
- Sometimes = 2
- Rarely = 1
- Never = 0

Therefore, based on a summative score, the maximum score is 24 and the minimum score is 0.

If the “Lodging Complaints” question is marked as “Not applicable”, it is treated as missing data.

Consequently, the care recipients are scored based only on the remaining five questions. The scores from each of these five questions (excluding “Lodging Complaints”) are added together to compute a

total score. The maximum possible score for these five questions is 20. To adjust this score to be equivalent to a scale that includes all six questions, refer to the Look-up Table below.

- 'Excellent' consumer experience is indicated where a care recipient scores between 22–24
- 'Good' consumer experience is indicated where a care recipient scores between 19–21
- 'Moderate' consumer experience is indicated where a care recipient scores between 14–18
- 'Poor' consumer experience is indicated where a care recipient scores between 8–13
- 'Very poor' consumer experience is indicated where a care recipient scores between 0–7

Look-up Table for the QCE-ACC scores when "Lodge Complaints" question is marked as "Not Applicable"

QCE-ACC score with Not Applicable marked for "Lodge Complaints" Rescaled to 0-24	
<i>Summative Score Calculated</i>	<i>Rescaled Score</i>
0	0.0
1	1.2
2	2.4
3	3.6
4	4.8
5	6.0
6	7.2
7	8.4
8	9.6
9	10.8
10	12.0
11	13.2
12	14.4
13	15.6
14	16.8
15	18.0
16	19.2
17	20.4
18	21.6
19	22.8
20	24.0

Organising QCE-ACC Data

Here is an example of how you can organise the data you collect using the QCE-ACC:

Variable name	ID	Respect	Decision-Making	Staff Skills	Health/Wellbeing	Relationships	Feedback
Variable description	Person ID number	4 = always	4 = always	4 = always	4 = always	4 = always	4 = always
		3 = mostly	3 = mostly	3 = mostly	3 = mostly	3 = mostly	3 = mostly
		2 = some-times	2 = some-times	2 = some-times	2 = some-times	2 = some-times	2 = some-times
		1 = rarely	1 = rarely	1 = rarely	1 = rarely	1 = rarely	1 = rarely
		0 = never	0 = never	0 = never	0 = never	0 = never	0 = never
Data row 1	1	4	3	3	3	4	4
Data row 1	2	4	2	3	2	4	4

Where there are **missing** or **ambiguous values** (e.g. 2 boxes are ticked for a single dimension on hard copy version of QCE-ACC) an overall summary score cannot be calculated.

Preference based scoring algorithm

Older person aged care specific and general population scoring algorithms are available for the QCE-ACC, facilitating its application in economic evaluation. Please contact the instrument developers for more information and to access the preference-based scoring algorithm/s for the QCE-ACC.



QCE-ACC Publications

Chen, G., Ratcliffe, J., Milte, R., Khadka, J. & Kaambwa, B. (2021). Quality of Care Experience in Aged Care: A Discrete Choice Experiment to Elicit Preference Weights with Over 10,000 Australians. *Social Science and Medicine*, 289, 114440, doi: [10.1016/j.socscimed.2021.114440](https://doi.org/10.1016/j.socscimed.2021.114440)

Cleland, J., Hutchinson, C., Khadka, J., Milte, R., Ratcliffe, J. (2021). What defines quality of care for older people in aged care? A comprehensive literature review. *Geriatrics and Gerontology International* Dec 15;21(10): 702.

Khadka, J., Ratcliffe, J., Chen, G., Kumaran, S., Milte, R., Hutchinson, C., Savvas, S. & Batchelor, F. (2020). A new measure of quality of care in aged care: psychometric assessment, and validation of the Quality of Care Experience (QCE) questionnaire. Adelaide: Caring Futures Institute, Flinders University.
<https://agedcare.royalcommission.gov.au/publications/research-paper-20-quality-care-experience-and-community-expectations>

Ratcliffe, J., Chen G., Khadka, J., Kumaran, S., Hutchinson, C., Milte, R., Savvas, S. & Batchelor, F. (2020). *Australia's aged care system: the quality of care experience and community expectations*. A research study commissioned by the Royal Commission into Aged Care Quality and Safety. Adelaide: Caring Futures Institute, Flinders University.



Organisation use only

Client Name or ID: _____



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The QCE-ACC tool was developed in Australia to measure the quality-of-care experience of those accessing aged care services in the community and in residential aged care.

The Flinders Caring Futures Institute is Australia's first fully dedicated research organisation for the study of self-care and caring solutions. We deliver quality research into self-care, health and wellness, care interventions, and health, ageing and social care systems and services.



Quality of Care Experience Aged Care Consumers

Self-Complete Version

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For each question, please mark the ONE box that best describes how you feel about your current situation.

Date of completion ____/____/____

1. I am treated with respect and dignity:

- ☐ Always
- ☐ Mostly
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

This relates to how staff speak to you and respect your wishes, privacy, and belongings.

2. I am supported to make my own decisions about the care and services I receive:

- ☐ Always
- ☐ Mostly
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

This relates to being able to make choices about the care you receive, e.g. choices related to care, food, and how you organise your day.

3. I receive care and support from aged care staff who have the appropriate skills and training:

- ☐ Always
- ☐ Mostly
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

This relates to how confident you feel that staff are able to provide quality care. e.g. administering medication safely, managing health conditions.

4. I receive services and supports for daily living that are important for my health and wellbeing:

- ☐ Always
- ☐ Mostly
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

This might include support for your physical health or your mental wellbeing, e.g. support to attend appointments, equipment to help you do daily tasks, assistance with taking medications.

5. I am supported to maintain my social relationships and connections with the community:

- ☐ Always
- ☐ Mostly
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

You can consider your relationships or friendships with fellow residents, staff, volunteers, family or community inside or outside of the residential care home.

6. I am comfortable lodging complaints with confidence that the appropriate action will be taken:

- ☐ Always
- ☐ Mostly
- ☐ Sometimes
- ☐ Rarely
- ☐ Never
- ☐ Not applicable

This relates to feeling comfortable to lodge a complaint with your provider, if needed, and feeling that your concerns will be taken seriously.

Organisation use only

Client Name or ID: _____

Optional

Relationship of proxy to the interviewee:

- ☐ Spouse
- ☐ Sibling (sister/brother)
- ☐ Son/daughter
- ☐ Grandchild
- ☐ Friend
- ☐ Other (please specify) _____

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Quality of Care Experience Aged Care Consumers

Proxy Version

The proxy should be a person who knows the interviewee well and sees them regularly

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For each question, please mark the ONE box that best describes [name of older person's] current situation (proxy perspective).

Date of completion ____/____/____

1. I am treated with respect and dignity:

- ☐ Always
- ☐ Mostly
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

This relates to how staff speak to you and respect your wishes, privacy, and belongings.

2. I am supported to make my own decisions about the care and services I receive:

- ☐ Always
- ☐ Mostly
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

This relates to being able to make choices about the care you receive, e.g. choices related to care, food, and how you organise your day.

3. I receive care and support from aged care staff who have the appropriate skills and training:

- ☐ Always
- ☐ Mostly
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

This relates to how confident you feel that staff are able to provide quality care. e.g. administering medication safely, managing health conditions.

4. I receive services and supports for daily living that are important for my health and wellbeing:

- ☐ Always
- ☐ Mostly
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

This might include support for your physical health or your mental wellbeing, e.g. support to attend appointments, equipment to help you do daily tasks, assistance with taking medications.

5. I am supported to maintain my social relationships and connections with the community:

- ☐ Always
- ☐ Mostly
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

You can consider your relationships or friendships with fellow residents, staff, volunteers, family or community inside or outside of the residential care home.

6. I am comfortable lodging complaints with confidence that the appropriate action will be taken:

- ☐ Always
- ☐ Mostly
- ☐ Sometimes
- ☐ Rarely
- ☐ Never
- ☐ Not applicable

This relates to feeling comfortable to lodge a complaint with your provider, if needed, and feeling that your concerns will be taken seriously.



Quality of Care Experience Aged Care Consumers

Interviewer Facilitated Version

Introduction

In order for us to measure the impact of the services and supports you are currently receiving we would like to talk to you about your quality of care experience.

To measure your experiences of care we are using the 'Quality of Care Experience: Aged Care Consumers' questionnaire. This questionnaire contains 6 questions and was developed in Australia.

Each question is a statement and there are five response options for each statement. These response options are the same for each of the 6 questions. I will go through these with you and repeat them if you need me to. When answering these questions, I would like you to think about how you feel about your current situation.

The QCE-ACC questionnaire is brief and should only take us around 5-10 minutes to complete. Are you ready to begin?



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Date of interview: ____/____/____

Client Name or ID: .._____

1. Respect and dignity

The first question is about respect and dignity. This relates to being treated with respect and dignity by carers and other staff. It can refer to the way in which you are spoken to, as well as respect for your preferences, privacy and possessions.

The statement is:

I am treated with respect and dignity

Before you answer, I will give you the five response options. They are:

- ☐ Always
- ☐ Mostly
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

So, which of those response options is true for you in response to "I am treated with respect and dignity"?

(Repeat statement and response options if needed.)

2. Making my own decisions

The next statement is about making your own decisions in relation to the care and supports you receive. This relates to being informed as well as supported to make choices. In addition to decisions about care services, you can also consider decisions related to food, activities you like to take part in, and how you organise your day.

The statement is:

I am supported to make my own decisions about the care and services I receive.

The response options are:

- ☐ Always
- ☐ Mostly
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

So, which of those response options is true for you in response to "I am supported to make my own decisions about the care and services I receive"?

(Repeat statement and response options if needed.)

3. Trained aged care staff

The third question is about how confident you are that the staff providing you with care and support are well trained and have appropriate skills to provide quality care.

The statement is:

I receive care and support from aged care staff who have the appropriate skills and training.

The response options are:

- ☐ Always
- ☐ Mostly
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

So, which of those response options is true for you in response to “I receive care and support from aged care staff who have the appropriate skills and training”?

(Repeat statement and response options if needed.)

4. Impact of services on health and wellbeing

The next question is about the impact of the services you receive on your health and general well-being. This refers to being encouraged and supported to engage in activities that are personally meaningful and that enhance your self-esteem and promote feelings of contentment.

The statement is:

I receive services and supports for daily living that are important for my health and wellbeing

The options are:

- ☐ Always
- ☐ Mostly
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

So, which of those response options is true for you in response to “I receive services and supports for daily living that are important for my health and wellbeing”?

(Repeat statement and response options if needed.)

5. Social Connections

The next statement is about maintaining social connections. This can include family, friends and acquaintances. If you are living in residential care, social connections can also include your connections with other people living in your residential care home, staff, volunteers, and people in the community who you interact with regularly and have built a relationship with.

The statement is:

I am supported to maintain my social relationships and connections with the community.

The options are:

- ☐ Always
- ☐ Mostly
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

So, which of those response options is true for you in response to “I am supported to maintain my social relationships and connections with the community”?

(Repeat statement and response options if needed.)

6. Lodging complaints

The final question is about whether you feel comfortable lodging complaints with your provider, and whether you would be confident that raising complaints would not affect the services and supports you receive.

The statement is:

I am comfortable lodging complaints with confidence that the appropriate action will be taken.

The options are:

- ☐ Always
- ☐ Mostly
- ☐ Sometimes
- ☐ Rarely
- ☐ Never
- ☐ Not applicable

So, which of those response options is true for you in response to “I am comfortable lodging complaints with confidence that the appropriate action will be taken”?

(Repeat statement and response options if needed.)

Appendix D



Quality of Life Aged Care Consumers

QOL-ACC User Guide:
Information on how to use the QOL-ACC instrument

Quality of Life – Aged Care Consumers:
A new instrument for measuring quality of life in aged care from the
perspective of older people receiving aged care services

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Introduction

This guide has been developed to provide users with background information and basic guidance for using the Quality of Life-Aged Care Consumers instrument (QOL-ACC). It provides information on the administration of the instrument, general principles, terms of use, definitions and references relating to the QOL-ACC instrument and information about how to present the results.

What is the QOL-ACC?

The QOL-ACC is the first quality of life instrument, developed from its inception with older Australians accessing aged care in both home and residential care settings. It has been designed specifically for quality assessment and economic evaluation in aged care to capture consumer (older person and family carer) focused quality of life outcomes from their own perspective.

The QOL-ACC is comprised of six questions focused on the following six key quality of life dimensions:



- (i) Mobility
- (ii) Pain management
- (iii) Emotional well-being
- (iv) Independence
- (v) Social relationships
- (vi) Leisure activities/hobbies

Each question has five response options (or levels) moving from a low-level frequency (experiencing the quality of life dimension 'none of the time') to a high level (experiencing the quality of life dimensions 'all of the time').

The respondent is asked to indicate his/her quality of life by ticking (or clicking on) the box against the most appropriate statement in each of the six questions to describe their current quality of life. This information can then be used as a quantitative measure of quality of life for the individual respondents.

How was the QOL-ACC Developed?

The QOL-ACC instrument was developed in a series of stages. The first stage (stage 1) involved a series of in-depth qualitative interviews with older people receiving home care packages (N=41) and in residential care (N=43) about what quality of life means to them.

This stage identified six key quality of life dimensions: mobility, pain management, emotional well-being, independence, social connections, and activities.

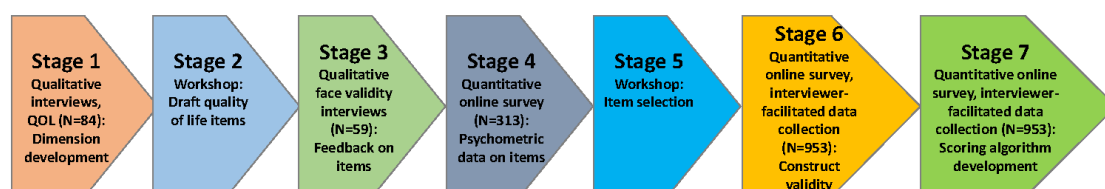


Stage 2 involved members of the research team, as well as consumers and aged care provider representatives reviewing the qualitative data and preparing draft items for each of the six dimensions, using the language, content and terminology used by the stage one older participants themselves in describing what quality of life means to them. A total of 28 items were developed.

In stage 3 these draft items were then subjected to face validity testing in qualitative interviews with older people in community and residential aged care (N=59). The items with the highest face validity were then extensively tested in stage 4 using quantitative methods with older people in a variety of aged care settings (N=313) and the psychometric properties of each item analysed. In stage 5, the research team led a workshop with consumer and aged care provider representatives to review the qualitative and quantitative data on the items and select a final item to represent each of the six quality of life domains.

In stage 6, a large Australia-wide sample of older adults accessing aged care services in home and residential care settings (N=953) were surveyed using online and interviewer administered modes of administration to provide further evidence of the construct validity of the QOL-ACC. Finally in stage 7 general population and older person aged care specific preference-based scoring algorithms were developed to facilitate the application of the QOL-ACC in economic evaluation (see 'preference based scoring algorithm' and 'QOL-ACC publications').

Figure 1: The seven stages of the development of the QOL-ACC



How can the QOL-ACC be used?

Scope

Quality of life is an important outcome and a key quality indicator in aged care. The QOL-ACC is a new instrument designed specifically to capture information about the quality of life of older people receiving aged care services and supports, either in their own homes or in a residential care facility.

The QOL-ACC is suitable for application in quality assessment as a person focused quality indicator. The QOL-ACC is also suitable for application in economic evaluation to assess the cost effectiveness of services and supports from the perspective of consumers, where effectiveness is measured and valued using quality of life as the main outcome.

QOL-ACC data can also be used to support service planning. Dimension level data across client groups can support aged care providers to tailor care and support services to improve quality of life, using the measure over time to ensure desired outcomes have been achieved.

The QOL-ACC instrument has been co-designed with older people and family carers accessing aged care Australia-wide. It has been designed to be administered with the older person themselves and can be used with older people who have no or mild cognitive impairment.

A proxy version of the QOL-ACC is available and can be used with an informal carer who knows the resident well (such as a family member who visits regularly) where the older person is unable to answer on their own behalf.

Ideally the proxy assessor should answer based on their own knowledge of the resident and their quality of life at the time that the QOL-ACC is administered. If no suitable family carer is available, a care worker could act as proxy for the older person if they know them well.

Accessing the QOL-ACC

By using the QOL-ACC you are agreeing not to alter the instrument wording, content and presentation in any way without permission from the development team. Where the QOL-ACC instrument is being used for research, this document and/or the research publications emanating from the QOL-ACC project should be appropriately referenced. Where the QOL-ACC instrument is being used by aged care providers for purposes beyond quality indicator reporting e.g., for research purposes, this user guide (see 'suggested citation') and/or the research publications emanating from the QOL-ACC project (see 'QOL-ACC publications') should be appropriately referenced.

Versions of the QOL-ACC

Several versions of the QOL-ACC are available including:

- Self-completion
- Proxy-completion
- Interviewer-facilitated completion



Scoring the QOL-ACC

The QOL-ACC should be scored as follows:

For each question, please mark the CNF box that best describes how you feel about your current situation.

Date of completion ____/____/____

<p>1. I am able to get around as much as I want to (with the use of mobility aids, e.g. wheelchair, walker, stick if you use them, or other people who help you):</p> <p><input type="checkbox"/> All of the time</p> <p><input type="checkbox"/> Most of the time</p> <p><input type="checkbox"/> Some of the time</p> <p><input type="checkbox"/> A little of the time</p> <p><input type="checkbox"/> None of the time</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>This is about being able to get to the places you need or want to go, indoors or outside in the community.</p> </div>	<p>4. I have as much independence as I want:</p> <p><input type="checkbox"/> All of the time</p> <p><input type="checkbox"/> Most of the time</p> <p><input type="checkbox"/> Some of the time</p> <p><input type="checkbox"/> A little of the time</p> <p><input type="checkbox"/> None of the time</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>You can live the life you choose and make your own decisions. This includes making decisions about your life or day-to-day decisions.</p> </div>
<p>2. When I experience pain, it is well managed:</p> <p><input type="checkbox"/> All of the time</p> <p><input type="checkbox"/> Most of the time</p> <p><input type="checkbox"/> Some of the time</p> <p><input type="checkbox"/> A little of the time</p> <p><input type="checkbox"/> None of the time</p> <p><input type="checkbox"/> Not applicable</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Management of pain may include the provision of heat packs, medication or other treatments from a doctor, physiotherapist or other healthcare professional.</p> </div>	<p>5. I have good social relationships with family and friends:</p> <p><input type="checkbox"/> All of the time</p> <p><input type="checkbox"/> Most of the time</p> <p><input type="checkbox"/> Some of the time</p> <p><input type="checkbox"/> A little of the time</p> <p><input type="checkbox"/> None of the time</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>This can include family, friends, acquaintances, and older people living with you, staff and volunteers.</p> </div>
<p>3. I am generally happy:</p> <p><input type="checkbox"/> All of the time</p> <p><input type="checkbox"/> Most of the time</p> <p><input type="checkbox"/> Some of the time</p> <p><input type="checkbox"/> A little of the time</p> <p><input type="checkbox"/> None of the time</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>This question is about your emotional well-being. It is about whether you are generally happy and content with your life.</p> </div>	<p>6. I have leisure activities/ hobbies I enjoy:</p> <p><input type="checkbox"/> All of the time</p> <p><input type="checkbox"/> Most of the time</p> <p><input type="checkbox"/> Some of the time</p> <p><input type="checkbox"/> A little of the time</p> <p><input type="checkbox"/> None of the time</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>This is about spending time doing things you enjoy. You might do these alone or with other people. They may be activities organised by aged care staff or family and friends.</p> </div>

Quality of life level responses are scored as:

- All of time = 4
- Most of the time = 3
- Some of the time = 2
- A little of the time = 1
- None of the time = 0

Therefore, based on a summative score, the maximum score is 24 and the minimum score is 0.

If the "Pain Management" question is marked as "Not applicable", it is treated as missing data. Consequently, the care recipients are scored based only on the remaining five questions. The scores

from each of these five questions (excluding “Pain Management”) are added together to compute a total score. The maximum possible score for these five questions is 20. To adjust this score to be equivalent to a scale that includes all six questions, refer to the Look-up Table below.

- ‘Excellent’ quality of life is indicated where a care recipient scores between 22–24
- ‘Good’ quality of life is indicated where a care recipient scores between 19–21
- ‘Moderate’ quality of life is indicated where a care recipient scores between 14–18
- ‘Poor’ quality of life is indicated where a care recipient scores between 8–13
- ‘Very poor’ quality of life is indicated where a care recipient scores between 0–7

Look-up Table for the QOL-ACC scores when “Pain management” question is marked as “Not Applicable”

QOL-ACC score with Not Applicable marked for “Pain management” Rescaled to 0-24	
<i>Summative Score Calculated</i>	<i>Rescaled Score</i>
0	0.0
1	1.2
2	2.4
3	3.6
4	4.8
5	6.0
6	7.2
7	8.4
8	9.6
9	10.8
10	12.0
11	13.2
12	14.4
13	15.6
14	16.8
15	18.0
16	19.2
17	20.4
18	21.6
19	22.8
20	24.0

Organising QOL-ACC Data

Here is an example of how you can organise the data you collect using the QOL-ACC:

Variable name	ID	Mobility	Pain management	Emotional Wellbeing	Independence	Social relationships	Leisure activities/hobbies
Variable description	Person ID number	4 = all of the time 3 = most of the time 2 = some of the time 1 = a little of the time 0 = none of the time	4 = all of the time 3 = most of the time 2 = some of the time 1 = a little of the time 0 = none of the time	4 = all of the time 3 = most of the time 2 = some of the time 1 = a little of the time 0 = none of the time	4 = all of the time 3 = most of the time 2 = some of the time 1 = a little of the time 0 = none of the time	4 = all of the time 3 = most of the time 2 = some of the time 1 = a little of the time 0 = none of the time	4 = all of the time 3 = most of the time 2 = some of the time 1 = a little of the time 0 = none of the time
Data row 1	1	4	2	4	3	2	3
Data row 1	2	2	3	3	9	4	4

Where there are **missing** or **ambiguous values** (e.g. 2 boxes are ticked for a single dimension on hard copy version of QOL-ACC) an overall summary score cannot be calculated.

Preference based scoring algorithm

Older person aged care specific and general population scoring algorithms are available for the QOL-ACC, facilitating its application in economic evaluation. Please contact the instrument developers for more information and to access the preference based scoring algorithm/s for the QOL-ACC.

QOL-ACC Publications

Cleland, J., Hutchinson, C., McBain, C., Walker, R., Milte, R., Khadka, J. & Ratcliffe, J. (2020). Developing dimensions for a preference-based quality of life instrument for older people receiving aged care services in the community, *Quality of Life Research*, 1-11. doi: 10.1007/s11136-020-02649-5.

Hutchinson, C., Cleland, J., McBain, C., Walker, R., Milte, R., Swaffer, K. & Ratcliffe, J. (2022). What quality of life dimensions are most important to older people in residential care? *Journal of Aging and Social Policy*. Published online 17 Oct 2022. doi: 10.1080/08959420.2022.2134691.

Hutchinson, C., Ratcliffe, J., Cleland, J., Walker, R., Milte, R., McBain, C., Corlis, M., Cornell, V. & Khadka, J. (2021). The integration of mixed methods data to develop the Quality of Life – Aged Care Consumers (QOL-ACC) measure, *BMC Geriatrics* 21:702. doi: 10.1186/s12877-021-02614-y

Khadka, J., Ratcliffe, J., Hutchinson, C., Cleland, J., Mulhern, B., Lancsar, E. & Milte, R. (2022). Assessing the construct validity of the Quality of Life-Aged Care Consumer (QOL-ACC): an aged care specific quality of life measure, *Quality of Life Research*, 31, 2849-2865.

Ratcliffe, J., Cameron, I., Lancsar, E., Walker, R., Milte, R., Hutchinson, C., Swaffer, K. & Parker, S. (2019). Developing a new quality of life instrument with older people for economic evaluations in aged care: study protocol, *BMJ Open*, 9,e028647, doi: 10.1136/bmjopen-2018-028647.

Cleland, J., Hutchinson, C., Milte, R., Khadka, J. & Ratcliffe, J. (2019). A review of the development and application of preference-based instruments with the older population, *Applied Health Economics and Health Policy*, 17(6), 781-801, doi: 10.1007/s40258-019-00512-4.



Client Name or ID: _____

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Quality of Life Aged Care Consumers

Self-Complete Version

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For further information [visit the website](http://www.qol-acc.org) (www.qol-acc.org) or [email the QOL-ACC/QCE-ACC Team](mailto:caringfutures@flinders.edu.au) (caringfutures@flinders.edu.au).

Version 3.0
November 2024

Flinders.edu.au

For each question, please mark the ONE box that best describes how you feel about your current situation.

Date of completion ____/____/____

1. **I am able to get around as much as I want to (with the use of mobility aids, e.g. wheelchair, walker, stick if you use them, or other people who help you):**

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

This is about being able to get to the places you need or want to go, indoors or outside in the community.

2. **When I experience pain, it is well managed:**

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time
- ☐ Not applicable

Management of pain may include the provision of heat packs, medication or other treatments from a doctor, physiotherapist or other healthcare professional.

3. **I am generally happy:**

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

This question is about your emotional wellbeing. It is about whether you are generally happy and content with your life.

4. **I have as much independence as I want:**

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

You can live the life you choose and make your own decisions. This includes making decisions about your life or day-to-day decisions.

5. **I have good social relationships with family and friends:**

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

This can include family, friends, acquaintances, and older people living with you, staff and volunteers.

6. **I have leisure activities/ hobbies I enjoy:**

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

This is about spending time doing things you enjoy. You might do these alone or with other people. They may be activities organised by aged care staff or family and friends.

Organisation use only

Client Name or ID: _____



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Optional

Relationship of proxy to the interviewee:

- ☐ Spouse
- ☐ Sibling (sister/brother)
- ☐ Son/daughter
- ☐ Grandchild
- ☐ Friend
- ☐ Other (please specify) _____

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Quality of Life Aged Care Consumers

Proxy Version

The proxy should be a person who knows the interviewee well and sees them regularly

Version 3.0
November 2024

For each question, please mark the ONE box that best describes [name of older person's] current situation (proxy perspective).

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1. I am able to get around as much as I want to
(with the use of mobility aids e.g. wheelchair, walker, stick
if you use them, or other people who help you):

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

This is about being able to get to the places you need or want to go, indoors or outside in the community.

2. When I experience pain, it is well managed:

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time
- ☐ Not applicable

Management of pain may include the provision of heat packs, medication or other treatments from a doctor, physiotherapist or other healthcare professional.

3. I am generally happy:

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

This question is about your emotional wellbeing. It is about whether you are generally happy and content with your life.

Date of completion ____/____/____

4. I have as much independence as I want:

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

You can live the life you choose and make your own decisions. This includes making decisions about your life or day-to-day decisions.

5. I have good social relationships with family and friends:

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

This can include family, friends, acquaintances, and older people living with you, staff and volunteers.

6. I have leisure activities/ hobbies I enjoy:

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

This is about spending time doing things you enjoy. You might do these alone or with other people. They may be activities organised by aged care staff or family and friends.



Quality of Life Aged Care Consumers

Interviewer Facilitated Version

Introduction

In order for us to measure the impact of the services and supports you are currently receiving we would like to talk to you about your quality of life.

To measure your quality of life we are using the Quality of Life: Aged Care Consumers questionnaire, known as the QOL-ACC. This questionnaire contains 6 questions and was developed in Australia with older people using aged care services in their own homes and in residential care.

Each question is a statement and there are five response options for each statement. These response options are the same for each of the 6 questions. I will go through these with you and repeat them if you need me to. When answering these questions I would like you to think about how your quality of life is TODAY.

The QOL-ACC questionnaire is brief and should only take us around 5-10 minutes to complete. Are you ready to begin?



Organisation use only

Client Name or ID: ..

Date of interview: ____/____/____

1. Mobility

The first question is about your mobility. Mobility is about being able to get to the places you need or want to go. This includes moving about indoors as well as outside spaces where you live or in the community.

Your mobility may be supported by the use of mobility aids such as walking sticks, walking frames, wheelchairs or mobility scooters.

The mobility statement is:

**I am able to get around as much as I want to.
(using mobility aids if you use them)**

Before you answer, I will give you the five response options. They are:

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

So, which of those response options is true for you TODAY in response to “I am able to get around as much as I want to”?

(Repeat statement and response options if needed.)

2. Pain Management

The next statement is about pain management. This relates to your experience of pain and whether you feel it is well managed. Managing pain can include the provision of heat packs, medication, or other treatments from a doctor, physiotherapist or other health care professional.

The statement is:

When I experience pain, it is well managed.

The response options are:

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time
- ☐ Not applicable

So, which of those response options is true for you TODAY in response to “When I experience pain it is well managed”?

(Repeat statement and response options if needed.)

3. Emotional well-being

The third question is about emotional well-being. Emotional well-being is about living your life without sadness, worry or stress. It is about whether you are generally happy and contented with your life.

The statement for emotional well-being is:

I am generally happy.

The response options are:

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

So, which of those response options is true for you TODAY in response to “I am generally happy”?

(Repeat statement and response options if needed.)

4. Independence

The next question is about independence. Independence is about living the life you choose and making your own decisions. This can be decisions about your life or day to day decisions such as how to structure your day, when you take your meals, when and how you undertake care or self-care activities, and when you go to bed.

The independence statement is:

I have as much independence as I want.

The options are:

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

So, which of those response options is true for you TODAY in response to “I have as much independence as I want”?

(Repeat statement and response options if needed.)



5. Social Connections

The next statement is about social connections. This can include family, friends and acquaintances. If you are living in residential care social connections can also include your connections with other people living in your residential care home, staff and volunteers who you interact with regularly and have built a relationship with.

The statement for social connections is:

I have good social relationships with family and friends.

The options are:

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

So, which of those response options is true for you TODAY in response to “I have good social relationships with family and friends”?

(Repeat statement and response options if needed.)

6. Activities

The final question is about activities, that is, spending time doing things you enjoy and value. Activities can be those you undertake alone, such as word puzzles, reading or sudoku or activities undertaken with other people such as playing cards, craft classes, coffee mornings or going on an outing.

These might be activities organised by aged care staff or those organised with family and friends. If you are a member of a church or other community organisation, activities could also include services or other events you attend.

The statement for activities is:

I have leisure activities / hobbies I enjoy.

The options are:

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

So, which of those response options is true for you TODAY in response to “I have leisure activities/hobbies I enjoy”?

(Repeat statement and response options if needed.)



Closing

Thank you for taking the time to answer these questions about your quality of life. We appreciate your responses. As we monitor quality of life regularly, we may ask you these questions again in the future.

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