Australian Government
Department of Health, Disability and Ageing

National Aged Care Quality Indicator Program (QI Program)

Frequently Asked Questions

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1 About the QI Program

What are the QI Program quality indicators?

All registered providers (providers) of approved residential care homes (aged care homes) must collect data across the 14 quality indicators:

- 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 officers.

Which aged care homes are required to participate in the QI Program?

The QI Program is mandatory for all Australian Government-funded providers of residential aged care, including residential respite services.

The following services are excluded from the QI Program:

- flexible care including transition care
- Support at Home Program
- Commonwealth Home Support Program
- Multi-Purpose Services Program
- the National Aboriginal and Torres Strait Islander Flexible Aged Care Program; and
- the Innovative Care Program.

Is the QI Program still mandatory if state or territories report similar data?

Yes. All Australian government-funded providers of residential aged care are required to collect and report quality indicator data. This ensures the QI Program data is nationally consistent and enables aged care homes to measure and monitor their performance against national averages.

Where can I find additional information and support?

The QI Program Manual – Part A (the Manual) includes definitions and instructions on how to collect and submit quality indicator data. Additionally, a range of QI Program support materials, such as QI Program Manual – Part B, are available on the QI resources page on the department's website.

Does the QI Program apply to home care services?

No. Currently home care services are not included in the QI Program. The QI Program is mandatory for all Australian government-funded providers of residential aged care only.

Why aren't GPs required to report on quality indicators?

QI Program data must be collected and reported by providers of residential aged care. Providers and care teams (including GPs) should use the QI Program data to engage in continuous quality improvement and work together to achieve better care outcomes. This includes using QI Program data to support the delivery of better care and to develop care management plans. A range of QI Program materials are available for aged care homes, allied health and medical professionals on the department's website.

Are residents receiving residential respite included in the QI Program?

Yes. Residents receiving residential respite must be included in QI Program data collection if they reside at the aged care home during the selected assessment period and do not meet exclusion criteria.

Exclusion criteria for each quality indicator are detailed in Manual Part A.

Are residents receiving end-of-life care included in the QI Program?

Residents receiving end-of-life care must be included in QI Program data collection for each of the quality indicators except for unplanned weight loss and activities of daily living. However, aged care homes are required to report the number of residents excluded from the unplanned weight loss and activities of daily living quality indicators because they are receiving end-of-life care.

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.* Is medical documentation required to show a resident is receiving end-of-life care?

Medical documentation is not required to be provided as part of data submission under the QI Program. However, in accordance with paragraph 154(a) of the Aged Care Act (the Act), providers must retain records relating to the collection and measurements of quality indicators including medical records, progress notes and other clinical records of residents, including those related to a

resident receiving end-of-life care. Providers are required to keep the records in written or electronic form for 7 years from the day the record is made or received.

Is consent required from residents to collect QI Program data?

Providers must seek the consent of residents for the assessments of pressure injuries and unplanned weight loss. Residents can also choose whether to complete the surveys for consumer experience (QCE-ACC) and/or quality of life (QOL-ACC). Those who choose not to complete the QCE-ACC or QOL-ACC surveys are considered to have withheld consent to complete the survey and must be noted in the reporting as an exclusion.

For quality indicators requiring consent, consent should be gained from residents prior to assessments taking place. For example, for weight loss quality indicators that require residents to be weighed at the start, middle and end of the reporting period (quarter), consent must be provided before each of these weight observation assessments. If a resident does not consent to any of the assessments, this should be noted as an exclusion in the QI Program data.

Consent does not need to be obtained from residents for the remaining quality indicators such as for restrictive practices and medication management. The data submitted under the QI Program must be de-identified to not contain personal information about residents. It is up to providers to issue residents a notice of collection of the information as per obligations under the Australian Privacy Principles (APP 5 – Notification of the collection of personal information). 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 residents.

How should a provider record consent from a resident?

The QI Program does not prescribe the format in which a provider is to seek and document consent from residents. This includes where consent is withheld.

Subject to some legislated exceptions such as Behaviour Support Plans, it is up to the provider to determine how it wishes to document information about the delivery of care and services, that also complies with the requirement to hold records of quality indicator measurements.

Are all residents for each quality indicator required to be assessed on the same day?

No. The Manual provides guidance on when and how quality indicator data collection should take place each reporting period. It is important the requirements outlined in the Manual for each quality indicator are followed. Providers are free to select dates and time periods that best suit their aged care home.

Is there a template to support recording data for each quality indicator?

Yes. Data recording templates for each quality indicator are available on the department's website. The templates automatically calculate and summarise QI Program data for submission through the Government Provider Management System (GPMS) Quality Indicator Application. Instructions on how to use the data recording templates are provided within each template.

Are aged care homes able to use their own templates to record QI Program data?

Yes. Aged care homes may use their own templates to collect quality indicator data providing the definitions and instructions defined in the Manual are adhered to.

When reporting quality indicator data, providers can only use the file upload template in the Government Provider Management System (GPMS) to upload data using the bulk upload functionality.

Are comments required for all quality indicators?

Comments are only a requirement for the unplanned weight loss and activities of daily living quality indicators. Providers must note residents who were excluded because they did not have quality indicator data recorded, including the reason why the data was not collected.

Comments for the remaining quality indicators are optional and typically used to note information to help aged care homes interpret their reports. Short and succinct comments are preferred. Comments stating null values (e.g. N/A, nil, no comment) or that describe information already provided in the data, such as restating figures in words, should not be included.

Providers must ensure the information compiled or derived in accordance with these requirements does not contain personal identifiable information about any of the residents.

What are the data submission requirements for providers who have had a change of entity and/or closed-combined services?

Providers who have provided care at any time in the reporting period to residents are still required to submit data for the period in which they provided care, including where a change of entity has occurred.

When providers combine two or more services into a single continuing service during a reporting period, it's important that:

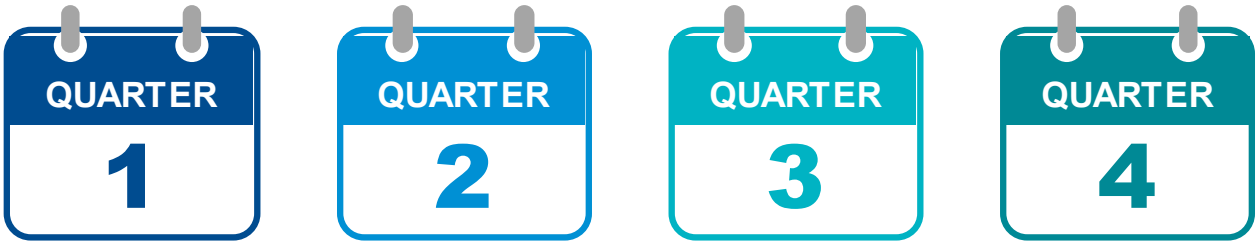
- the discontinuing service reports QI Program data from the start of the reporting period to the date the service is closed-combined
- the continuing service reports QI Program data for the entire reporting period, including the QI Program data for the discontinued service from the date the service is closed-combined.

What happens when residents are absent from the aged care home for assessment periods?

All residents must be included in the QI Program data collection if they reside or are receiving respite at the aged care home during the selected assessment period and do not meet exclusion criteria. Exclusion criteria for each quality indicator are detailed in the Manual.

When and where do I submit the QI Program data?

QI Program data must be collected and entered through GPMS every quarter based on the financial year calendar. Providers must submit quality indicator data no later than the 21st day of the month after the end of each quarter. QI Program data cannot be submitted late, and extensions are not permitted. This includes aged care homes submitting their data through a benchmarking company.



1 July to 30 September	1 October to 31 December	1 January to 31 March	1 April to 30 June
DUE DATE 21 October	**DUE DATE 21 January**	**DUE DATE 21 April**	**DUE DATE 21 July**

What happens if there is an issue uploading data before the due date?

It is the responsibility of providers to ensure QI Program data is submitted accurately and on time according to the requirements of the Manual.

Providers should work on proactive submission schedules to ensure support issues can be resolved by the My Aged Care service provider and assessor helpline. If you require assistance submitting QI Program data, please contact the My Aged Care service provider and assessor helpline on 1800 836 799.

Is it compulsory to set targets?

No. Setting a target or benchmark for each quality indicator is optional.

However, setting targets can assist with continuous quality improvement at your organisation. A target rate for each quality indicator provides an opportunity to identify a minimum level of improvement. A significant change, either below or above set targets, should prompt analysis to identify possible opportunities for quality improvement.

What quality indicators contribute to the Star Ratings?

Pressure injuries, restrictive practices, unplanned weight loss, falls and major injury and medication management currently inform the Quality Measures rating. The Quality Measures Ratings contributes to an aged care home's Overall Star Rating. For more information please see the Star Ratings website.

2 Pressure injuries

Which classification system is used to report pressure injuries?

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

Who should undertake observation assessments for pressure injuries?

A full-body observation assessment should be conducted for each resident by someone who understands the ICD-10-AM pressure injury classification system and has knowledge to do so accurately and safely. Providers must consult with a suitably qualified health practitioner if there is uncertainty about the presence or stage of a pressure injury.

What if a resident does not provide consent to undergo an observation assessment for pressure injuries?

Residents who withhold consent to undergo an observation assessment for pressure injuries must be excluded from the pressure injuries quality indicator and recorded in the number of residents excluded because they withheld consent.

What if a resident has more than one pressure injury?

All pressure injuries must be assessed and the number of residents with presence of a pressure injury must be recorded against each of the six pressure injury stages. Therefore if a resident has more than one pressure injury, all stages are to be reported. The quality indicator does not require you to report the number of pressure injuries a resident has overall.

Are pressure injuries acquired outside the aged care home counted?

Yes. Providers must record each resident with one or more pressure injuries, irrespective of where they were acquired during the reporting period against each of the six pressure injury stages, and as part of the total number of residents with one or more pressure injuries. In addition, providers must separately record the number of residents with one or more pressure injuries acquired outside of the aged care home, and against each of the six pressure injury stages during the reporting period.

3 Restrictive practices

What are restrictive practices?

Section 17 of the Act defines restrictive practices as any practice or intervention that has the effect of restricting the rights or freedom of movement of an individual.

The QI Program restrictive practices quality indicator measures and reports data relating to all restrictive practice, excluding chemical restraint. This includes mechanical restraint, physical restraint, environmental restraint and seclusion, as defined in section 17-5 of the Aged Care Rules (the Rules).

How is restrictive practices data collected?

The collection of restrictive practices data involves a single three-day record review for each resident every reporting period. 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 residents at the aged care home. Details of all relevant definitions, collection and reporting requirements for restrictive practices are detailed in Section 9 of the QI Program Manual – Part A.

If equipment is used to protect a resident from harm is this considered a restrictive practice?

Yes, use of equipment to protect a resident should be included in reporting for the restrictive practice quality indicator. This is consistent with restrictive practice legislation, defining this as mechanical restraint – as outlined on Section 9 of the Manual.

Mechanical restraint is any practice or intervention that is, or that involves, the use of a device to prevent, restrict or subdue a resident's movement for the primary purpose of influencing the resident's behaviour and is considered a restrictive practice. This does not include the use of a device for therapeutic or non-behavioural purposes in relation to the resident.

If a resident has requested bed rails, are these included in reporting for restrictive practice?

Yes. All listed forms of restrictive practices in the Manual, including instances the resident or their representative instigate or request the restrictive practice, should be reported under the restrictive practices quality indicator for the purposes of the QI Program.

If a resident is immobile, is this classified as a restrictive practice?

If there is no practice or intervention that has the effect of restricting the rights or freedom of movement of a resident, it is not a restrictive practice. However, if a resident requires a mobility aid and the aid is taken away from them to limit their movement this would be considered a restrictive practice.

What constitutes a resident's environment?

For the purposes of the QI Program, a resident's environment is taken to include the resident's room, any common areas within the facility, and the common grounds outside of the facility which are part of the aged care home's grounds, including gardens. It does not include areas within the aged care home that a resident would not normally be permitted, such as meal preparation areas, maintenance areas or medication storage areas. Additionally, it does not include other resident's rooms.

Environmental restraint may involve restricting a resident from accessing a room or area within their environment, or an item or activity. For example, locking away cutlery, mobile phones, or restricting a resident from accessing activities such as watching television or making tea or coffee is environmental restraint.

What is a secure area?

A secure area is any area of an aged care home where a resident is prevented from leaving freely by means of locked doors, gates, keypads or other mechanism.

For the purposes of the QI Program, restraint through the use of a secure area is environmental restraint. As defined in section 17-5 of the Rules, environmental restraint is a practice or intervention that restricts, or that involves restricting, an individual 's free access to all parts of the individual's environment (including items and activities) for the primary purpose of influencing the individual's behaviour.

For example, number keypads on doors are an environmental restraint if it prevents a resident from accessing a part of their environment or limits their movement. If an aged care home provides codes to mobile residents who are able to remember them, and can leave the aged care home without assistance, this would not be considered an environmental restraint.

Are residents who are immobile and in a secure area included in reporting of restrictive practices?

All residents in a secure area, including those who are immobile, must meet the definition of restraint to be included in reporting of restrictive practices.

A secure area is included as an environmental restraint when it restricts, or involves restricting, a resident's free access to all parts of the resident's environment (including items and activities) for the primary purpose of influencing the resident's behaviour.

QI Program reporting includes residents subject to the use of a restrictive practice as well as the sub-category of residents who were subject to the use of a restrictive practice exclusively through the use of a secure area.

Are residents in a memory support unit, secure or locked area included in reporting of restrictive practices?

All residents in a secure area, such as a locked memory support unit, must meet the definition of environmental restraint or seclusion to be included in reporting under the restrictive practices quality indicator.

A memory support unit, secure or locked area should be included as an environmental restraint when it restricts, or involves restricting, a resident's free access to all parts of the resident's

environment (including items and activities) for the primary purpose of influencing the resident's behaviour.

QI Program reporting includes residents subject to the use of a restrictive practice (excluding chemical restraint) as well as the sub-category count of residents restricted exclusively through the use of a secure area.

4 Unplanned weight loss

What is the guidance relating to clothing when weighing residents?

It is important to record the weight for each resident residing at the aged care home, using a calibrated scale, and to weigh residents:

- at or around the same time each month
- at around the same time of the day; and
- wearing clothing of a similar weight (e.g. a single layer without coats or shoes).

Can the same measurements that were taken for significant weight loss be used for consecutive unplanned weight loss?

Finishing weights for the previous reporting period ('previous weight') and current reporting period may have already been recorded for each resident as part of assessments and measurements made for significant unplanned weight loss. The same finishing weights can be used for consecutive unplanned weight loss and do not need to be collected again.

Is there a minimum weight loss requirement in order for the weight loss to be recorded?

For the purposes of the QI Program, providers of aged care must report the number of residents who experienced:

- significant unplanned weight loss (5% or more); and
- consecutive unplanned weight loss of any amount.

For significant unplanned weight loss, a weight loss of 5% or more is reported. There is no minimum weight loss requirement for weight loss to be recorded for consecutive unplanned loss. The starting, middle and finishing weight of each resident assessed for unplanned weight loss, including weight loss of any amount, must be recorded.

If a resident loses weight but has been prescribed a weight loss strategy, should their weight loss be counted?

For the purposes of the QI Program, unplanned weight loss is counted where there is no written strategy or ongoing record relating to planned weight loss for the resident.

If a resident has a written record from a medical doctor or dietitian, which includes intentional 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 resident.

If a resident loses weight during a hospital stay, is this counted?

If the resident has experienced unplanned weight loss which occurred while they were admitted to hospital, and this is identified when they have returned to the aged care home, this is counted for reporting in the QI Program.

If the resident was hospitalised and as a result missed any of the required weight records, this should be counted in the number of residents excluded due to missing weight records, noting that the exclusions differ between consecutive and significant weight loss as detailed in QI Program Manual – Part A. Comments as to why the weight recording/s are absent (e.g. the resident was hospitalised) must be included.

Are residents receiving end-of-life care counted for unplanned weight loss?

Residents who are receiving end-of-life care are not required to be weighed and are excluded from the unplanned weight loss quality indicator. Providers must record the total number of residents excluded because they are receiving end-of-life care.

Are respite residents residing for short periods counted for unplanned weight loss?

All residents receiving residential respite must be included in the QI Program data collection if they reside at the aged care home during the selected assessment period and do not meet exclusion criteria. Exclusion criteria for each quality indicator are detailed in the QI Program Manual – Part A.

5 Falls and major injury

How do providers choose the collection date for falls and major injury?

Data collection for falls and major injury involves a single review of the care records of each resident for the three months comprising the reporting period. For this reason, the review must take place after the end of the reporting period and before data submission (due on the 21st day of the month after the end of the quarter).

If a resident is found on the ground following an unwitnessed fall, should this be counted and recorded for the falls and major injury quality indicator?

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. All falls at the aged care home during the reporting period should be recorded, including where a resident is found on the ground after an unwitnessed fall.

If a resident places themselves on the ground to enable them to do other things, is this classified as a fall?

No. A fall is an event that results in a person coming to rest inadvertently on the ground or floor or other lower level.

If a fall takes place outside of a provider's care or aged care home should this be recorded?

No. Falls, and falls resulting in major injury, that occurred while the resident was away from the aged care home and not under direct supervision of aged care home staff are not included.

A resident fell once with no injury and a second time resulting in major injury, how is this recorded?

Providers must record whether each resident experienced one or more falls at the aged care home during the reporting period. They must additionally record whether each resident experienced one or more falls resulting in major injury at the aged care home during the reporting period. A resident who experiences a fall and then another fall resulting in major injury must be recorded as both having a fall and having a fall resulting in major injury.

Are deceased residents included in the falls and major injury quality indicator?

For the purposes of the QI Program, data collection is a single review of the care records of each resident for the entire reporting period. If a resident passes away during the reporting period, they are included in the data collection for the duration of the reporting period before they passed away. Residents who were absent from the aged care home for the entire reporting period are excluded.

If a resident passes away as a consequence of the fall or if they have a fall that results in major injury but passes away as a result of a different cause, a fall should be reported against falls and further reported against falls resulting in major injury. If a resident has a fall which results in no injury or a minor injury but passes away as the result of a different cause, then only the fall needs to be reported.

6 Medication management

What is a medication?

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. It includes prescription and non-prescription medicines, including complementary health care products, irrespective of the administered route.

Can providers rely on pharmacy reports for quality indicator data collection?

Pharmacy reports should be maintained as accurate and up-to-date records and may therefore be used for the polypharmacy count of prescribed medications.

Records of administration of antipsychotic medications, however, will be held only within the aged care home's medication charts and/or administration records. Pharmacy reports can therefore not be used for the antipsychotics category of the medication management quality indicator.

How are PRN and non-PRN medications distinguished?

PRN medications are to be distinguished according to the definition used across aged care, health and medicine in Australia. PRN stands for 'pro re nata' which means 'as required'. PRN medications are administered when a resident may require an occasional dose of medication or may require an additional dose between regularly prescribed doses.

PRN medications are typically listed in a separate section in medication charts to distinguish from medications that need to be given regularly.

Polypharmacy

What is polypharmacy and why is it important?

For the purposes of the QI Program, polypharmacy is defined as the prescription of nine or more medications to a resident. Regular monitoring of polypharmacy is important because polypharmacy has been associated with reduced quality of life and harms such as adverse drug events, falls, cognitive decline, and hospitalisation.

Are there certain medications that are excluded from the count of medications for polypharmacy?

Yes. While any medication with an active ingredient is counted in the polypharmacy quality indicator, there are exceptions which must not be included in the count of medications. These include:

- lotions, creams or ointments used in skin and wound care
- dietary supplements, including Ensure
- oral administered vitamins, minerals and herbal medicines, including homeopathic preparations

- short-term medications, such as antibiotics or temporary eye drops; and
- PRN medications.

Are medicated creams such as those for rashes or thrush included in the count for polypharmacy?

Lotions, creams or ointments used in skin and wound care are not included in the count of medications for the polypharmacy quality indicator, even if some may contain active ingredients. This includes medicated creams for rashes or thrush.

Dencorub and other anti-inflammatory creams and gels such as Diclofenac are not included irrespective of their use. Lotions, creams and ointments used for infected skin lesions and skin cancers such as 'fluorouracil cream' are also not included. Cold sore preparations and other anti-fungal creams, and steroid creams are also not included.

Transdermal oestrogen or other hormonal creams that penetrate the skin for hormonal treatment are to be included if treatment is long term. Short term or PRN use of these medicines is not to be included in the count under the polypharmacy indicator.

Pessaries such as oestrogen or antifungal preparations are to be included in long term use however, short term or PRN use of these medicines is not to be included in the count.

Are vitamin injections, such as Vitamin B12, included in the count of medications for polypharmacy?

Vitamin injections, such as Vitamin B12, are classified as a medicine (chemical substance) and should be included in the count of medications for polypharmacy. Dietary supplements consumed orally, including vitamin tablets, are excluded from the medications count for the polypharmacy quality indicator.

How are dietary supplements defined?

For the purposes of the QI Program, a dietary supplement is a manufactured product intended for ingestion and to supplement one's diet in forms such as tablets, capsules, powders or liquids. These may include but are not limited to oral vitamins, herbal supplements, fish oils, amino acids and enzymes. Vitamin tablets (e.g. calcium, vitamin D or multivitamins), vitamin liquids (e.g. iron or B vitamin formulations) and oral nutritional supplements are not included in the medication count for QI Program purposes. All oral (ingested) vitamin supplements are excluded from the count irrespective of whether they are used as a preventative (e.g. calcium) or to treat a medically diagnosed deficiency (e.g. thiamine).

Is oxygen therapy counted as a medication?

No, oxygen is not counted as a medication within the medication management quality indicator.

Are products like Metamucil or Movicol to be counted as medications?

Dietary supplement stool softeners such as Metamucil are generally excluded from the count of medications for polypharmacy. It is important to note, long term use of laxative medications such as Movicol are included in the medication count. Short-term or PRN use is not included in the count of medication.

Are non-prescribed medicines such as saline nasal spray and sodium bicarb mouth wash counted as a medication?

Short-term medications and PRN medications, which may include mouthwashes and nasal sprays, are not to be included in the count of medications for polypharmacy.

Are eye drops counted as a medication?

For the purposes of the QI Program, lubricant eye drops are not included as medication irrespective of long-term use. However, medicated eyedrops may be included if used long-term but not in short term use or PRN applications.

Are medications with more than one active ingredient counted as more than one medication for polypharmacy?

For the purposes of the QI Program, any medication with an active ingredient is counted for polypharmacy, except for those listed as exclusions. Data is not collected on the number of active ingredients within a single medication. A single medication with more than one active ingredient is counted as one medication for the polypharmacy quality indicator.

Are medications administered more than once a day counted as more than one medication for polypharmacy?

The number of times a medication is administered in a day should not be counted for polypharmacy. For example, if a resident with diabetes is injected three times a day with a short acting insulin and once at night with a long-acting insulin, this should be counted as two medications (one short and one long acting).

A resident was on leave with family on the collection date, are they excluded from the count for polypharmacy?

Only residents who were a hospital admitted patient on the collection date are excluded from the polypharmacy category of the medication management quality indicator. All other residents must be included.

Antipsychotics

Is there a list of antipsychotic medications counted for antipsychotics?

The following non-exhaustive list of antipsychotic medications can be accessed in the Australian Medicines Handbook.

- Amisulpride
- Droperidol
- Periciazine
- Aripiprazole
- Flupentixol
- Quetiapine
- Asenapine
- Haloperidol
- Risperidone
- Brexpiprazole
- Lurasidone
- Trifluoperazine
- Chlorpromazine
- Olanzapine
- Ziprasidone
- Clozapine
- Paliperidone
- Zuclopenthixol
- Cariprazine

Does a resident need to have a specific diagnosis of psychosis to be counted?

The medication charts and/or administration records of all residents residing at the aged care home during the seven-day assessment period must be included and reviewed for antipsychotic medications. Residents who receive an antipsychotic medication during the seven-day assessment period are recorded. Of the residents who received antipsychotic medication, providers must additionally report the residents who have a medically diagnosed condition of psychosis.

What is Psychosis?

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. Residents receiving end-of-life care may also experience psychosis.

Are psychotropics such as antidepressants counted as antipsychotics?

No. Psychotropic medications are a broader class of medications than antipsychotics. The QI Program only requires recording of antipsychotic medications received during the seven-day assessment period, irrespective of diagnosis. Residents with a medically diagnosed condition of psychosis who received an antipsychotic are then recorded as an additional sub-category within the antipsychotics category of the medication management quality indicator.

Are antipsychotics counted according to what is administered or what is prescribed?

All instances of a resident receiving an antipsychotic medication must be recorded. Providers must review each resident's medication charts and/or administration records for the seven-day assessment period and record whether each resident received an antipsychotic medication. This includes PRN medications.

How are residents who received antipsychotics on more than one occasion during the seven-day assessment period reported?

The antipsychotics category of the medication management quality indicator collects data on the percentage of residents who received antipsychotic medications. If a resident receives an antipsychotic medication on more than one occasion during the seven-day assessment period, they are recorded once as receiving an antipsychotic medication.

Are PRN and one-off antipsychotic doses counted?

Yes. Each resident's medication charts and/or administration records must be reviewed for the seven-day assessment period and recorded if they received an antipsychotic medication. For the antipsychotic medication indicator only, this includes PRN medications.

Are prescribed antipsychotics recorded against both medication management categories?

Yes. If a resident is prescribed an antipsychotic medication, whether it be for the treatment of a diagnosed condition of psychosis or not, this should be included in the count of medications for the polypharmacy quality indicator as well as the antipsychotics quality indicator. It is important to note, reporting for the polypharmacy indicator does not include short-term or PRN use of antipsychotics or other medications.

Should providers aim to have zero residents receiving antipsychotic medication?

No. Antipsychotic medications are appropriate when used in the treatment of chronic mental health conditions such as schizophrenia and to manage psychosis, including psychosis which can be associated with health conditions such as delirium.

Residents with dementia may also develop psychotic symptoms and benefit short-term from antipsychotic medication if other non-pharmacological measures have not been effective.

Can care staff select the collection date?

No. The collection date must be varied between reporting periods and must not be identified to, or conducted by, staff directly involved in care.

7 Activities of daily living

What is considered a decline in ADLs?

For the purposes of the QI Program, decline in activities of daily living (ADLs) is defined as a decline in the ADL assessment total score of one or more points. This is determined by comparing the ADL assessment total score from the current reporting period with the previous reporting period. Both ADL assessment total scores must be available to provide this result.

Which assessment tool is used to measure activities of daily living for each resident?

The Barthel Index of Activities of Daily Living is the assessment tool used to measure ADLs for the purposes of the QI Program. The assessment tool is included in Appendix A of the QI Program Manual – Part A.

Who should conduct the ADL assessment?

The ADLs assessment should be conducted by staff who understand the Barthel Index of Activities of Daily Living tool and are familiar with the resident being assessed. Assessment scoring is based on the resident's actual performance over the previous 24–48 hours, noting longer periods will be relevant for some items (e.g. bowel and bladder).

When should we complete the assessments for this quality indicator?

The ADL assessment for each resident is to be conducted around the same time each reporting period.

How many assessments are required within the reporting period for each resident?

A single assessment for each resident is completed around the same time every reporting period and compared to their ADL assessment total score from the previous reporting period to determine decline.

Do we need to undertake direct testing for the ADL assessment?

No. The ADL assessment can be completed using existing knowledge of the resident obtained through routine personal care, asking the resident, referring to care records or by direct observation. Direct testing of the resident is not required.

How should performance be assessed when conducting an ADL assessment?

The ADL assessment (the Barthel Index of Activities of Daily Living) scoring is based on the resident's actual performance over the previous 24–48 hours, noting longer periods will be relevant for some items (e.g. bowel and bladder). A resident's performance for each of the ten items is

established using the best available evidence, including existing knowledge of the resident obtained through routine personal care, asking the resident, referring to care records or by direct observation.

How do providers report quality indicator data when an ADL assessment score for the previous reporting period is not available?

Residents who do not have a previous ADL assessment total score are reported as an exclusion. Providers must include comments as to why the previous ADL assessment total score is absent.

It is important to note, providers must conduct an ADL assessment for each resident residing at the aged care home. This assessment total score will support reporting on the ADLs quality indicator in the following reporting period.

If the resident does not have an ADL assessment total score for the previous reporting period are they excluded?

Each resident residing at the aged care home must be assessed for the ADL quality indicator. Residents who do not have an ADL assessment total score recorded for the previous reporting period:

- will not be reported in the number of residents assessed; and
- will be reported as an exclusion with comments explaining why the ADL assessment total score for the previous reporting period is absent (e.g. new admission to the aged care home).

It is important to note, providers must conduct an ADL assessment for each resident residing at the aged care home. This assessment total score will support reporting on the ADLs quality indicator in the following reporting period.

How should the score for stairs be recorded in an aged care home with no stairs?

A resident's performance for each of the ten items, including the use of stairs, of the Barthel Index of Activities of Daily Living is established using the best available evidence. This can include using existing knowledge of the resident obtained through routine personal care, asking the resident, referring to care records or by direct observation. Direct testing of a resident's ability to use stairs is not required. If evidence is not available to establish a resident's ability to use stairs the relevant item on the ADL assessment receives a null score.

8 Incontinence care

Which assessment tool is used to collect information on incontinence associated dermatitis (IAD)?

The Ghent Global IAD Categorisation Tool is the classification system used to collect information on IAD for the purposes of QI Program. This tool is included in Appendix B of the QI Program Manual – Part A.

How many categories of IAD are reported against?

There are four sub-categories of IAD under the Ghent Global IAD Categorisation Tool to be reported against for the purposes of the QI Program. This includes:

- 1A: Persistent redness without clinical signs of infection
- 1B: Persistent redness with clinical signs of infection
- 2A: Skin loss without clinical signs of infection; and
- 2B: Skin loss with clinical signs of infection.

Who should undertake observational assessments for IAD?

Incontinence related care and skin integrity should be monitored as part of the resident's routine personal care (e.g. bathing and toileting). Diagnosis and categorisation of IAD 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 as part of routine care and if identified, escalate to appropriately trained staff for further assessment. Providers must consult with a suitably qualified health practitioner if there is uncertainty about the presence or severity of IAD.

When should residents be assessed for IAD?

Incontinence related care and skin integrity should be monitored as part of the resident's routine personal care (e.g. bathing and toileting). For the purposes of the QI Program, a single IAD assessment is completed for each resident with incontinence around the same time each reporting period. Any residents with incontinence who experience IAD must be reported.

When is a resident considered to have incontinence?

For the purposes of the QI Program, a resident has incontinence if urinary incontinence occurs more than once a day, or faecal incontinence more than once a week.

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.

In addition, for the purposes of the QI Program, a resident has incontinence if they require urinary catheters for passing urine.

How are residents with catheters assessed and recorded?

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

Incontinence related care and skin integrity should be monitored as part of the resident's routine personal care (e.g. bathing and toileting). For the purposes of the QI Program, a single IAD assessment is completed for each resident with incontinence, including those with catheters, around the same time each reporting period. Any residents with incontinence, including those with catheters, who experience IAD must be reported.

If the resident did not have incontinence, do they still need to be assessed for IAD?

No. For the purposes of the QI Program, residents who do not have incontinence are excluded from IAD assessment.

Is IAD acquired outside of the aged care home counted?

Yes. Providers must record each resident with IAD that was acquired outside of the aged care home during the reporting period as part of the total number of residents with IAD and against the four sub-categories IAD acquired outside of the aged care home is not reported separately.

9 Hospitalisation

What is an emergency department presentation?

For the purposes of the QI Program, an emergency department presentation occurs when a resident 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).

When should data be collected for the hospitalisation quality indicator?

The collection date must take place in the 21 days after the end of the quarter, in order to review records for the entire reporting period.

Are admissions to hospital reported as part of the hospitalisation quality indicator?

- Yes. Residents who had one or more emergency department presentations or hospital admissions during the reporting period are included as part of the additional reporting requirements for the hospitalisation quality indicator.
- For the purposes of the QI Program, a hospital admission occurs when a resident 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).

Are medical appointments at a hospital reported as part of the hospitalisation quality indicator?

No. Medical appointments at a hospital are not reported as part of the hospitalisation quality indicator. However, if a resident is admitted to hospital after the medial appointment they should be included in the additional reporting requirements for the hospitalisation quality indicator.

Are planned presentations to the emergency department reported as part of the hospitalisation quality indicator?

Yes. For the purposes of the QI Program, an emergency department presentation occurs when a resident presents to an emergency department or urgent care centre, whether planned or unplanned.

Are GP referrals to the emergency department reported as part of the hospitalisation quality indicator?

Yes. For the purposes of the QI Program, an emergency department presentation occurs when a resident presents to an emergency department or urgent care centre, irrespective of the type of referral.

Should we avoid sending residents to the emergency department or hospital?

- No. Hospitalisation is recognised as an important and necessary element of care, including for older Australians. Aged care homes should never avoid or prevent hospital transfer or emergency department presentation if it is required.
- The purpose of the hospitalisation quality indicator is to support quality improvement by enabling providers to identify and monitor emergency department presentations that could be avoided with appropriate care.

10 Workforce

Are all staff working at our aged care home included in workforce quality indicator reporting?

No. For the purposes of the QI Program, workforce quality indicator reporting includes:

- service managers
- nurse practitioners or registered nurses
- enrolled nurses; and
- personal care workers or nursing assistants.

Are part-time, labour hire or agency staff included in workforce quality indicator reporting?

Yes. For the purposes of the QI Program, workforce quality indicator reporting includes all types of employment (e.g. permanent, part-time, labour hire and agency) for the following:

- service managers
- nurse practitioners or registered nurses
- enrolled nurses; and
- personal care workers or nursing assistants.

Are there definitions for the staff included in the workforce quality indicator reporting?

Yes. Definitions provided in Section 18.0 of the QI Program Manual – Part A include:

- **Service managers** are staff who manage the operations of an aged care home. This includes leading staff teams to ensure the provision of quality care, in line with the aged care standards.
- **Nurse practitioners** are registered as nurse practitioners with the Nursing and Midwifery Board of Australia and have completed approved education to be recognised as a nurse practitioner by Services Australia.
- **Registered nurses (RNs)** are staff who have completed the prescribed education preparation, demonstrate competence to practice, and are registered under the National Law as an RN in Australia.
- **Enrolled nurses (ENs)** are staff who provide nursing care under the direct or indirect supervision of an RN. They have completed the prescribed education preparation and demonstrate competence to practice under the National Law as an EN in Australia.
- **Personal care workers/ Nursing assistants** are staff classified under Schedule B.2 in the Aged Care Award 2010 as an Aged Care employee – direct care level 1 to level 6. A provider may employ a PCW in an equivalent role in a corresponding award/enterprise agreement; or an individual contract/agreement. The primary responsibility of a PCW/ NA is to directly provide personal care services to residents under the supervision of a RN or EN.

Who is considered ‘employed staff’?

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

However, additional reporting includes staff who worked any hours during the previous reporting period as:

- service managers
- nurse practitioners or registered nurses
- enrolled nurses; and
- personal care workers or nursing assistants.

When is an employed staff member counted as ‘turnover’ for data collection?

For the purposes of the QI Program, a staff member is considered to have stopped working if they have a period of at least 60 consecutive days in the reporting period in which they have not worked as:

- service managers
- nurse practitioners or registered nurses
- enrolled nurses; and
- personal care workers or nursing assistants.

Is leave or promotion treated different for ‘turnover’?

No. A staff member is considered to have stopped working if they have a period of at least 60 consecutive days in the reporting period in which they have not worked. This includes leave (planned or unplanned) or promotion.

The purpose of the workforce quality indicator is to support quality improvement through promoting continuity of care. Continuity of care and meaningful relationships with staff are crucial element for a resident’s wellbeing in residential care.

Can we use our own staff records to collect this data?

Yes. Aged care homes are encouraged to use or adapt existing staff records to collect and report workforce quality indicator data providing information is sufficient, accurate and in accordance with the Manual.

How do we report staff employed across multiple aged care homes?

If a staff member works across multiple aged care homes, they will be assessed and reported against each relevant aged care home, in line with the definitions provided in the Manual.

How do we report staff working multiple roles within an aged care home?

If a staff member works in more than one outlined role, they will be assessed and reported against each relevant outlined role, in line with the definitions provided in the Manual.

11 Consumer experience

Which assessment tool is used to collect information on consumer experience?

The Quality of Care Experience Aged Care Consumers © *Flinders University 2022* (QCE-ACC) tool is a six question assessment tool used in the QI Program to collect and report on the consumer experience of residents at the aged care home during the reporting period. This tool is included in Appendix C of the QI Program Manual – Part A.

When should we use different versions of the QCE-ACC?

For the purposes of the QI Program, the QCE-ACC:

- Self-completion version can be offered to residents with no or mild cognitive impairment. Aged care homes are encouraged to facilitate anonymous, self-completion of the QCE-ACC where possible.
- Interviewer facilitated version can be offered to residents who require additional support to complete the assessment (e.g. support with reading the questions or writing responses). A staff member, informal carer or relative can assist the resident complete the QCE-ACC by using the interview-facilitated version.
- Proxy-completion version can be offered to residents with moderate or severe cognitive impairment who are unable to complete the QCE-ACC independently or with assistance from an interviewer. An informal carer or person who knows the resident well and interacts with them regularly can complete the QCE-ACC on behalf of the resident by using the proxy-completion version.

Is it mandatory for residents to complete the QCE-ACC each reporting period?

No. For the purposes of the QI Program aged care homes are required to offer residents the appropriate version of the QCE-ACC every reporting period. Aged care homes may wish to remind residents to complete the QCE-ACC however they should not be pressured or forced to do so.

Residents who do not choose to complete the QCE-ACC for an entire reporting period are reported as an exclusion.

Is anonymous collection of the QCE-ACC required?

Aged care homes are encouraged to facilitate anonymous self-completion of the QCE-ACC, where possible. This approach will help aged care homes collect the most accurate feedback to guide quality improvement.

When should a new resident be offered the QCE-ACC?

All residents, including new residents, should be offered the appropriate version of the QCE-ACC at around the same time every reporting period. The QCE-ACC is based on the quality of care experience at the time of administration of the QCE-ACC.

How can we support residents who speak languages other than English to complete the QCE-ACC?

The interviewer facilitated version can be offered to residents who require additional support to complete the QCE-ACC assessment (e.g. support with reading the questions or writing responses). A staff member, informal carer or relative can assist the resident complete the QCE-ACC by using the interview facilitated version.

Can a staff member act as a proxy for residents who cannot complete the QCE-ACC self-completion or interview facilitated versions?

Yes. If a suitable informal carer is not available to support proxy completion of the QCE-ACC, a staff member could act as proxy for the resident if they know them well. 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.

If a resident is unable to complete the QCE-ACC due to cognitive impairment, are they excluded?

No. A QCE-ACC assessment must be offered to each resident for completion, around the same time every reporting period. Providers should support residents with cognitive impairment to access the most appropriate version of the QCE-ACC (self-completion, interview facilitated or proxy-completion).

Exclusions for the consumer experience quality indicator include:

- residents who were absent from the aged care home for the entire reporting period, and
- residents who did not choose to complete the consumer experience assessment for the entire reporting period.

How do we report residents who did not choose to complete the consumer experience assessment?

For the purposes of the QI Program, residents and their proxies who did not choose to complete the QCE-ACC for the entire reporting period are excluded and reported separately.

Do we need to pay a licensing fee to use the QCE-ACC tool?

No. Providers do not need to pay a licensing fee to use the QCE-ACC tool for the purposes of collecting and reporting quality indicator data for the QI Program. The intellectual property rights contained within the QCE-ACC materials and tools are owned by Flinders University and have been licensed to the Department of Health, Disability and Ageing. By using the QCE-ACC tool you are agreeing not to alter the instrument wording, content and presentation in any way without permission from Flinders University.

How can providers support anonymous data collection for consumer experience using the data recording templates?

The data recording templates are intended as a working resource to support data collection within an aged care home. Aged care homes may wish to use internal reference numbers to track the number of consumer experience assessments received to support internal auditing processes.

Personal information or unique reference numbers are not required when submitting data as part of quarterly QI Program reporting.

What is included in *Total number of individuals offered* to complete a survey for the Consumer Experience tabs of the GPMS data recording template?

After inputting all resident names and their information in Table 2, the 'Total number of individuals offered a consumer experience assessment' listed in Table 1 will only equal the total number of residents that completed the survey via the three collection methods. This field will not include residents that were offered the survey but chose not to complete it or were absent from the aged care home on the date of collection.

For example, if you have 22 residents who were offered a survey, 3 chose not to complete the survey and 6 were absent, the 'Total number of individuals offered a consumer experience assessment through self-completion, interviewer facilitated completion or proxy-completion' will be equal to 13.

How are rescaled scores categorised where the 'not applicable' option is selected for question 6 of QCE-ACC?

The resident's scores for each of the six questions are added together to give a total score. The guidance provides a rescaling tool if a resident answers 'not applicable'. In line with standard mathematical rounding conventions, rescaled scores where the "not applicable" option has been selected for question 6 of QCE-ACC ('lodge complaints') should be rounded to the nearest whole number for categorisation purposes. Specifically:

- If the decimal component is less than 0.5, the score is rounded down (e.g. 7.2 becomes 7)
- If the decimal is 0.5 or greater, the score is rounded up (e.g. 21.6 becomes 22).

This ensures consistency and clarity in interpreting and categorising rescaled scores. Once scored, these are then assigned to one of five categories describing overall consumer experience.

Examples include:

Summative Score Calculated	Rescaled Score	Rounded Score	Category
6	7.2	7	Very Poor
11	13.2	13	Poor
18	21.6	22	Excellent

12 Quality of life

Which assessment tool is used to collect information on quality of life?

The Quality of Life Aged Care Consumers © *Flinders University 2022* (QOL-ACC) is a six-question assessment tool used in the QI Program to collect and report on the quality of life of residents at the aged care home during the reporting period. This tool is included in Appendix D of the QI Program Manual – Part A.

When should we use different versions of the QOL-ACC?

For the purposes of the QI Program, the QOL-ACC:

- Self-completion version can be offered to residents with no or mild cognitive impairment. Aged care homes are encouraged to facilitate anonymous, self-completion of the QOL-ACC where possible.
- Interviewer facilitated version can be offered to residents who require additional support to complete the assessment (e.g. support with reading the questions or writing responses). A staff member, informal carer or relative can assist the resident complete the QOL-ACC by using the interview-facilitated version.
- Proxy-completion version can be offered to residents with moderate or severe cognitive impairment who are unable to complete the QOL-ACC independently or with assistance from an interviewer. An informal carer or person who knows the resident well and sees them regularly can complete the QOL-ACC on behalf of the resident by using the proxy-completion version.

Is it mandatory for residents to complete the QOL-ACC each reporting period?

No. For the purposes of the QI Program aged care homes are required to offer residents the appropriate version of the QOL-ACC every reporting period. Aged care homes may wish to remind residents to complete the QOL-ACC however they should not be pressured or forced to do so.

Residents who do not choose to complete the QOL-ACC for an entire reporting period are reported as an exclusion.

Is anonymous collection of the QOL-ACC required?

Aged care homes are encouraged to facilitate anonymous self-completion of the QOL-ACC, where possible. This approach will help aged care homes collect the most accurate feedback to guide quality improvement.

When should a new resident be offered the QOL-ACC?

All residents, including new residents, should be offered the appropriate version of the QOL-ACC at around the same time every reporting period. The QOL-ACC is based on the quality of care experience at the time of administration of the QOL-ACC.

How can we support residents who speak languages other than English to complete the QOL-ACC?

The interviewer facilitated version can be offered to residents who require additional support to complete the QOL-ACC assessment (e.g. support with reading the questions or writing responses). A staff member, informal carer or relative can assist the resident complete the QOL-ACC by using the interview facilitated version.

Can a staff member act as a proxy for residents who cannot complete the QOL-ACC self-completion or interview facilitated versions?

Yes. If a suitable informal carer is not available to support proxy completion of the QOL-ACC, a staff member could act as proxy for the resident if they know them well. 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 QOL-ACC is administered.

If a resident is unable to complete the QOL-ACC due to cognitive impairment, are they excluded?

No. A QOL-ACC assessment must be offered to each resident for completion, around the same time every reporting period. Providers should support residents with cognitive impairment to access the most appropriate version of the QOL-ACC (self-completion, interview facilitated or proxy-completion).

Exclusions for the quality of life quality indicator include:

- residents who were absent from the aged care home for the entire reporting period, and
- residents who did not choose to complete the quality of life assessment for the entire reporting period.

How do we report residents who did not choose to complete the quality of life assessment?

For the purposes of the QI Program, residents and their proxies who did not choose to complete the QOL-ACC for the entire reporting period are excluded and reported separately.

Do we need to pay a licensing fee to use the QOL-ACC tool?

No. Providers do not need to pay a licensing fee to use the QOL-ACC tool for the purposes of collecting and reporting quality indicator data for the QI Program. The intellectual property rights contained within the QOL-ACC materials and tools are owned by Flinders University and have been licensed to the Department of Health, Disability and Ageing. By using the QOL-ACC tool you are agreeing not to alter the instrument wording, content and presentation in any way without permission from Flinders University.

How can providers support anonymous data collection for quality of life using the data recording templates?

The data recording templates are intended as a working resource to support data collection within an aged care home. Aged care homes may wish to use internal reference numbers to track the number of quality of life assessments received to support internal auditing processes. Personal

information or unique reference numbers are not required when submitting data as part of QI Program reporting.

What is included in *Total number of individuals offered* to complete a survey for the Quality of Life tabs of the GPMS data recording template?

After inputting all resident names and their information in Table 2, the 'Total number of individuals offered a quality of life assessment' listed in Table 1 will only equal the total number of residents that completed the survey via the three collection methods. This field will not include residents that were offered the survey but chose not to complete it or were absent from the aged care home on the date of collection.

For example, if you have 22 residents who were offered a survey, 3 chose not to complete the survey and 6 were absent, the 'Total number of individuals offered a consumer experience assessment through self-completion, interviewer facilitated completion or proxy-completion' will be equal to 13.

How are rescaled scores categorised where the 'not applicable' option is selected for question 2 of QOL-ACC?

The resident's scores for each of the six questions are added together to give a total score. The guidance provides a rescaling tool if a resident answers 'not applicable'. In line with standard mathematical rounding conventions, rescaled scores where the "not applicable" option has been selected for question 2 of QOL-ACC ('pain management') should be rounded to the nearest whole number for categorisation purposes. Specifically:

- If the decimal component is less than 0.5, the score is rounded down (e.g. 7.2 becomes 7)
- If the decimal is 0.5 or greater, the score is rounded up (e.g. 21.6 becomes 22).

This ensures consistency and clarity in interpreting and categorising rescaled scores. Once scored, these are then assigned to one of five categories describing overall quality of life.

Examples include:

Summative Score Calculated	Rescaled Score	Rounded Score	Category
6	7.2	7	Very Poor
11	13.2	13	Poor
18	21.6	22	Excellent

13 Enrolled Nursing

Why do we have a ‘care minutes’ quality indicator for allied health and lifestyle but not for enrolled nursing?

Providers already report on enrolled nursing care minutes, and they are available on the My Aged Care website.

The enrolled nursing (EN) quality indicator reports EN care minutes as a proportion of total care minutes as well as in combination with registered nurses (RN). This gives a picture of an aged care home’s workforce and skill mix, and innovative care models.

Where do contracted nurse practitioner hours sit, for example, a wound consultant that is on a referral basis?

Providers should report nurse practitioner (NP) hours with registered nurse (RN) in the QFR under residential labour costs and hours. This applies where the NP is paid for by the provider.

Note: Where the NP works for a GP practice working with residents under the guidance of the GP funded by Medicare (and/or the resident directly), it should not be reported.

14 Allied Health

What professions are considered ‘allied health’ for inclusion in the allied health staffing quality indicator?

For the purposes of the QI Program professions within allied health services are consistent with the current definitions in the Quarterly Financial Report (QFR).

Included professions are physiotherapists, occupational therapists, speech pathologists, podiatrists, dietitians, allied health assistants, and ‘other allied health’. ‘Other allied health’ includes art therapists, audiologists, chiropractors, counsellors, exercise physiologists, diabetes educators, music therapists, osteopaths, psychologists and social workers.

In the context of the new indicators, are psychologists categorised as ‘medical’, ‘other allied services’ or another category of workforce?

Psychologists are listed under ‘other allied health’ in the data guidance for the QFR. They are therefore considered to provide services delivered by an allied health professional under the QI Program. The QFR data definitions template contains the full list of allied health professions included in reporting.

Are allied health assistants included although they may not be university trained or registered as a health professional?

Allied health assistants (AHAs) are included in the new allied health quality indicator. They work under the supervision and delegation of allied health professionals to provide allied health services to residents and are included in the QFR definition.

There is no requirement for AHAs to be university qualified or registered according to current QFR and QI Program policy.

Are optometrists included? They are not listed in the QFR but would meet the definition of an allied health professional.

For the QI Program, providers are only required to capture allied health disciplines already captured in QFR, and this is consistent across the two data points. Optometrists are not currently captured in QFR so they do not need to be reported for the QI Program.

For the ‘percentage of recommended allied health services received’ indicator, do providers only need to report on allied health services paid by the aged care home via salaries and/or invoices paid to agency/contractor staff?

The intent of the ‘Percentage of recommended allied health services received’ data point is to measure whether recommended allied health services have been received, therefore providers need to report any recommended allied health services received from any of the included allied health professions, regardless of whether they have received invoices or paid salaries for them.

What is a 'recommended' allied health service, and who can make the recommendation? Does it include requests from resident/family?

A ‘recommended’ allied health service is any allied health service included in a residents’ care plan or progress notes. (see ‘definition of a care plan’).

Recommendations and requests for allied health services need to be documented in residents’ care plans and/or progress notes to be included in the ‘percentage of recommended allied health services received’ QI data point. The source of the recommendation should also be recorded. This could be from a health practitioner or a request from a resident or their representative.

If allied health services were considered for the resident, then determined to be not required, and no referral was sent this would not be considered a ‘recommended’ allied health service, and care plan documentation should be updated to reflect this.

Does the recommendation have to be a referral? Can it include routine referrals e.g. after a fall?

The recommendation can be through a referral or another type of service request.

If a referral is sent to an allied health service this should be included in the resident’s care and services plan and recorded as recommended for this data point.

For example, if the aged care home policy states a resident must receive physiotherapy after a fall, this is a ‘recommended’ service for the reporting period in which the fall occurred. This is provided that the recommendation is documented in the care and services plan/progress notes.

What happens when the care plan states that an allied health service is recommended ‘as required’ or annually?

When an allied health service is required annually, this service should be recorded as ‘recommended’ in the reporting period in which it is due. If the service is then received in that reporting period, it would also be recorded as ‘received’, provided correct documentation is included in the resident’s care plan and/or progress notes.

An allied health service that is recommended ‘as required’ should be recorded as ‘recommended’ in the reporting period when the service is required. If the service is then received in that reporting period, it would also be recorded as ‘received’.

What is the definition of having 'received' allied health services? How does a home document this for each type and where?

For the QI Program, a recommended allied health service has been received if the appointment/ visit occurred and was documented in the reporting period. This needs to be recorded in the resident’s care and services plan and/or progress notes.

What happens if an allied health service is recommended but the resident declines the service?

If the resident has a recommendation for an allied health service but then declines the service, this would be counted as ‘recommended’ but not ‘received’ in that reporting period. In this situation we encourage the provider to include a comment in Government Provider Management System (GPMS) to say that the service was recommended but was declined by the resident.

What documents are considered the resident's care plan for the purposes of the QI Program?

Care and services plans include documents which describe the current care needs, goals and preferences of individuals and include strategies for risk management and preventative care, as described in the Aged Care Quality Standards. For the purposes of the QI Program, progress notes and reports provided by allied health professionals are included.

There is no prescribed format that the care and services plan must take. It can be a single document or several documents that show an overview of the care and services to be delivered. It should be accessible to residents, carers, and staff providing care and services. Allied health recommendations listed in progress notes are sufficient for this data point. An allied health letter of referral that can be uploaded into software and supported by a progress note would meet the requirements for a 'recommended' service.

Will care minutes for allied health only capture face-to-face clinical care, or non-clinical care as well?

As part of the QFR requirements, all allied health hours should be reported.

Care minutes for allied health will capture direct clinical care and any other service provided, as calculated from hours worked reported in the QFR.

The 'allied health care minutes' quality indicator draws data directly from QFR to minimise the reporting burden for providers in introducing the new quality indicators.

When reporting labour hours in the QFR, direct care activities may include both direct in-person assistance (face-to-face) and direct care activities that are not undertaken face-to-face, for example, writing up care plans or organising a referral, non-clinical tasks specific to food and nutrition etc. Allied health support provided through virtual telehealth, such as video conference, can also contribute towards care hours.

If the recommendation to receive allied health services is made on the last day of the reporting period and the service is planned to be received the following week, what are the rules to report this?

This will still be required to be reported as a recommendation but not against the recommended service received. In this situation we encourage the provider to include a comment in GPMS to say that it was recommended on the last day of the reporting period, and an appointment has been booked in the next reporting period.

This service should then be captured as both recommended and received in the following reporting period.

What happens if a service is recommended and received multiple times in one reporting period? For example, a resident is recommended to attend a falls and balance group with a physiotherapist, then the same resident has a fall in that reporting period and requires more physiotherapy services?

For the ‘recommended allied health services received’ data point, providers only need to count recommendations and received services once per allied health discipline.

In this example, one recommended physiotherapy service and one received physiotherapy service would be recorded in that reporting period, regardless of how many new physiotherapy recommendations or services the resident received in that quarter.

15 Lifestyle Officers

Do the services of an external provider of leisure and lifestyle services count toward lifestyle officer care minutes?

Yes, providers need to report labour hours worked by agency and staff on external contracts providing leisure and lifestyle services via the QFR. They will be included as part of the lifestyle officer care minutes QI.

Can care staff time be reported under the lifestyle officer care minutes quality indicator

Staff employed in hybrid roles which include diversional/lifestyle/recreation/activities officer as part of their job description are counted in QFR reporting. As per QFR guidance, this reporting should match the times that are allocated to each role. An example is a staff member employed for two days as a lifestyle officer, and 3 days as a personal care worker.