Australian Government
Department of Health

National Aged Care Mandatory Quality Indicator Program (QI Program)

Manual 2.0 – Part A

National Aged Care Mandatory Quality Indicator Program Manual 2.0 – Part A

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

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Disclaimer

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.

Acknowledgements

The Commonwealth would like to acknowledge the work undertaken by the Victorian Department of Health from 2006 to 2021 which assisted the Commonwealth to establish the National Aged Care Mandatory Quality Indicator Program.

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1.0 Introduction to the National Aged Care Mandatory Quality Indicator Program

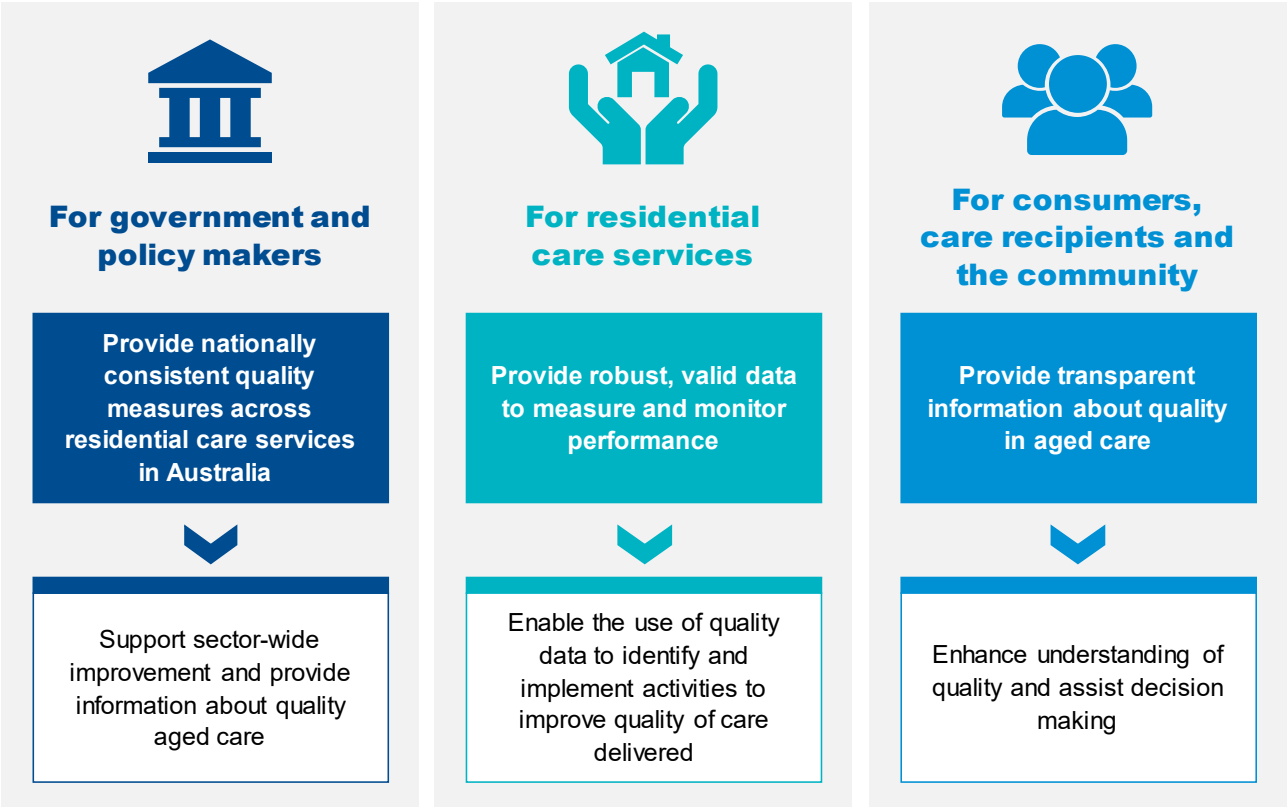
Participation in the National Aged Care Mandatory Quality Indicator Program (QI Program) has been a requirement for all approved providers of residential care services since 1 July 2019. The QI Program requires quarterly reporting against five quality indicators across crucial care areas – pressure injuries, physical restraint, unplanned weight loss, falls and major injury, and medication management.

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; and
- over time, to give consumers transparent information about quality in aged care to assist decision making.

FIGURE 1: SUMMARY OF QI PROGRAM OBJECTIVES



2.0 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 five crucial care areas. Data for each quality indicator is collected through measurements and assessments within each of the categories set out in Figure 2 below. Information is then compiled or derived, and is provided to the Secretary of the Australian Government Department of Health (Secretary), or the Secretary's delegate, in accordance with the legislative requirements.

The Aged Care Quality and Safety Commission (Commission) is responsible for operational administration of the QI Program, including QI Program compliance. QI Program data reported by approved providers of residential aged care 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 five quality indicators, comprising of eight categories, in accordance with the table below.

FIGURE 2: SUMMARY OF QI PROGRAM QUALITY INDICATORS

2.1. Percentage value for quality indicators

For each of the quality indicators, the percentage value is derived using the following formula:

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

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 legislation, residential care services must collect data consistently using the methods prescribed in the *National Aged Care Mandatory Quality Indicator Program Manual 2.0 – Part A* (Manual).

Residential care services must record and submit their quality indicator data into the My Aged Care provider portal (provider portal). Further information is outlined in sections 8 to 14 of this Manual.

The provider portal will:

- capture, process, and display information from residential care services about their quality indicator data; and
- provide reports to residential care services in relation to their quality indicator data.

The provider portal will use the quality indicator data to produce reports for each residential care service. Residential care services will be able to access these reports through the *Reports and documents* tile of the provider portal.

Residential care services will be able to interpret quality indicator data and related reports and use this information to influence quality of care and implement continuous quality improvement.

The approved provider is responsible for ensuring that quality indicator data is submitted. This remains the responsibility of the approved provider despite any other organisation, such as a commercial benchmarking service, being involved in the submission of the data.

Further guidance relating to the provider portal is in Part C of this Manual.

3.0 Quality indicator data submission

Pursuant to section 26 of the *Accountability Principles 2014* (Accountability Principles), residential care services must collect data for each quality indicator and enter it via the provider portal in order to make the information available to the Secretary, unless otherwise agreed by the Australian Government Department of Health (department) (for example, if another organisation is being engaged to do so). The quality indicator data must be collected and entered every quarter (three months) 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**. Further guidance relating to quality indicator data submission is in Part C of this Manual.

FIGURE 3: DATES FOR SUBMISSION OF QUALITY INDICATOR DATA

4.0 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 provider portal's *Quality Indicator* tile. The data recording templates are available on the department and Aged Care Quality and Safety Commission websites. Instructions on how to use the data recording template are provided in the template.

5.0 Measurements and assessments – 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.

6.0 Record keeping

For each quality indicator an approved providers 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.

7.0 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 observational 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 and the resulting percentage value reported. 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.

8.0 Pressure injuries

8.1. Overview of pressure injuries

A pressure injury is a localised injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure, shear, or a combination of these factors[1]. Pressure injuries are potentially life threatening, decrease the care recipient's quality of life, and are expensive to manage. Regular monitoring of pressure injuries is important because pressure injuries may develop rapidly are a painful, costly, and often preventable complication of which many older Australians are at risk.

Approved providers of residential aged care 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 Wound Management Association (2014)
[2] National Centre for Classification in Health, *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification.* 11th ed. 2019.
[3] European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance. *Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline. The International Guideline*. Emily Haesler (Ed.). EPUAP/NPIAP/PPPIA:2019.

TABLE 2: PRESSURE INJURIES QUALITY INDICATOR OVERVIEW

Percentage of care recipients with pressure injuries, reported against six pressure injury stages

COLLECTION

- One observation assessment for each care recipient, around the same time every quarter

QUALITY INDICATOR REPORTING

- 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:
  - 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

- 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:
  - Stage 1 Pressure Injury
  - Stage 2 Pressure Injury
  - Stage 3 Pressure Injury
  - Stage 4 Pressure Injury
  - Unstageable Pressure Injury
  - Suspected Deep Tissue Injury

EXCLUSIONS

- 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 a localised injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure, shear, or a combination of these factors[4].

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:

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 sough (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.

[4] Australian Wound Management Association (2014)

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.
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: *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 as per Step 7 below.*

   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
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.

8.3.2. Inclusions for pressure injuries

All care recipients must be assessed for pressure injuries except those listed in *8.3.3. Exclusions for pressure injuries*.

8.3.3. Exclusions for pressure injuries

Care recipients who, for the entire quarter:

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

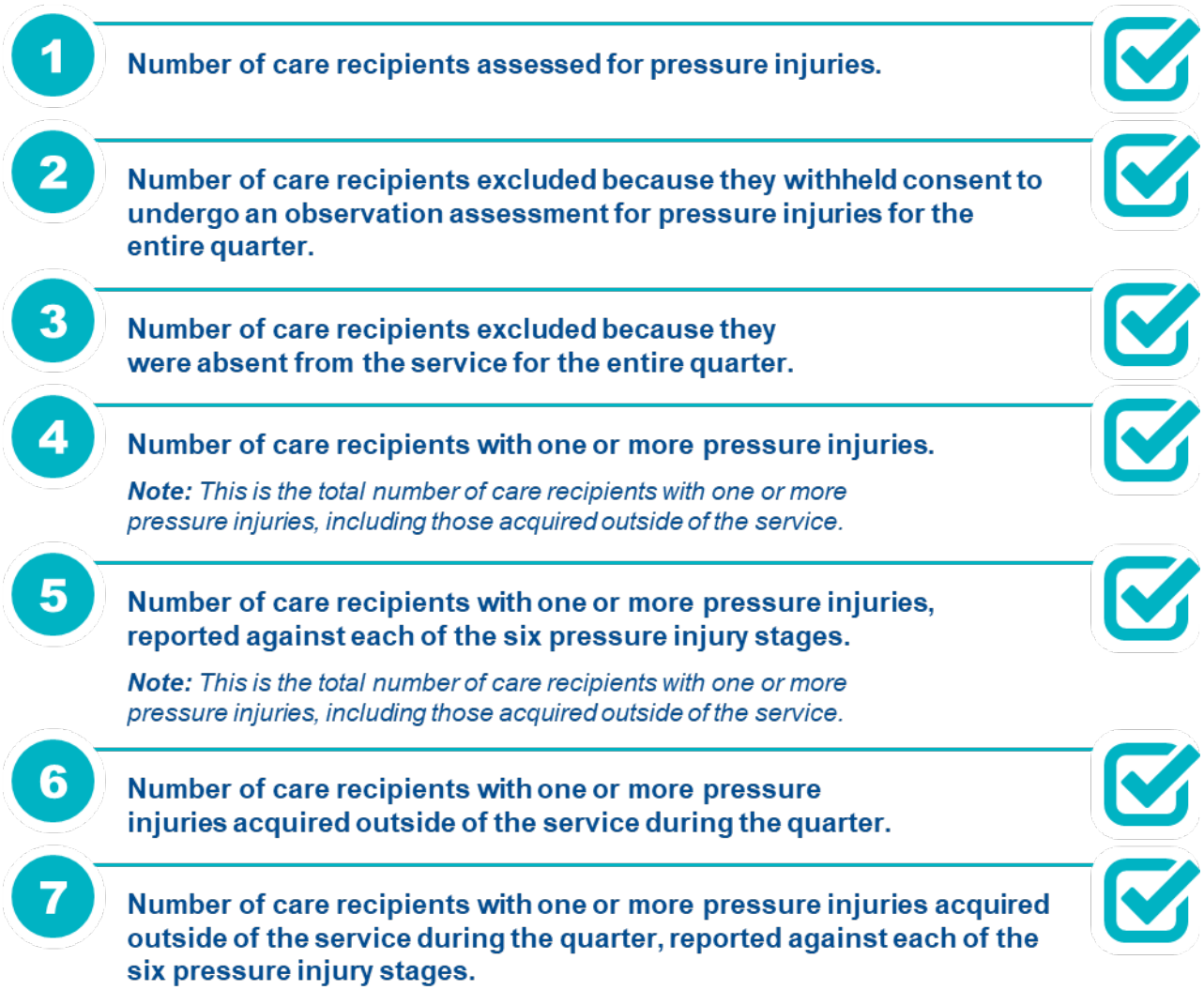
are excluded from assessment for pressure injuries.

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.

FIGURE 4: REQUIREMENTS FOR DATA REPORTING ON PRESSURE INJURIES



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 the provider portal 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 Part B of this Manual.

9.0 Physical restraint

9.1. Overview of physical restraint

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 physical restraint quality indicator measures and reports data relating to all restrictive practice, 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 aged care must collect and report on physical restraint 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 4: PHYSICAL RESTRAINT QUALITY INDICATOR OVERVIEW

Percentage of care recipients who were physically restrained	**COLLECTION** • A single three-day record review for each care recipient every quarter **QUALITY INDICATOR REPORTING** • Care recipients who were physically restrained **ADDITIONAL REPORTING** • Care recipients assessed for physical restraint • Care recipients who were physically restrained exclusively through the use of a secure area • Collection date **EXCLUSIONS** • Care recipients who were absent from the service for the entire three-day assessment period

9.2. Key terms for physical restraint

For the purposes of the QI Program, **physical restraint** 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:
    a. 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
    b. 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 to be 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) for the primary purpose of influencing the care recipient's behaviour
- *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;

    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 physical restraint for the purposes of the QI Program.

9.3. Measurements and assessments for physical restraint

The purpose of assessing a care recipient through the process set out below is to collect data relating to the physical restraint 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 physical restraint.
3. Record the care recipients who 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 physically restrained 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 physical restraint (see section 15F of the Quality of Care Principles).

   Note: *Physical restraint must be recorded, even if a care recipient or their representative have provided consent to the use of the restraint.*
5. Record whether each care recipient was physically restrained (once or more and including the use of secure areas) on any occasion during the three-day assessment period.
6. Of the care recipients physically restrained during the three-day assessment period recorded in Step 5 above, record whether the physical restraint was exclusively through the use of a secure area.

9.3.1. Inclusions for physical restraint

All care recipients must be assessed for physical restraint except those listed in *9.3.2. Exclusions for physical restraint*.

9.3.2. Exclusions for physical restraint

Care recipients who were absent from the service for the entire three-day assessment period are not required to be assessed.

9.4. Data reporting for physical restraint

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.

1. **The collection date for the quarter.**
2. **Number of care recipients whose records were assessed for physical restraint over the three-day assessment period.**
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 physically restrained (once or more and including the use of secure areas) on any occasion during the three-day assessment period.**
5. **Number of care recipients physically restrained during the three-day assessment period exclusively through the use of a secure area.**

9.5. How to report physical restraint

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

9.6. Additional resources for physical restraint

More information and resources related to physical restraint are available at www.health.gov.au and in Part B of this Manual.

10.0 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 and consequence of disease. The two categories within this quality indicator are:

1. significant unplanned weight loss (this Section), and
2. consecutive unplanned weight loss (see Section 11 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 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 aged care must collect and report on significant unplanned weight loss data quarterly, according to the requirements set out in this Manual.

TABLE 5: SIGNIFICANT UNPLANNED WEIGHT LOSS QUALITY INDICATOR OVERVIEW

Percentage of care recipients who experienced significant unplanned weight loss (5% or more)	**COLLECTION** • The weight of each care recipient is collected in the last month (finishing weight) of the quarter and compared to their weight at the last month (finishing weight) of the previous quarter to determine percentage of weight loss **QUALITY INDICATOR REPORTING** • Care recipients who experienced significant unplanned weight loss (5% or more) **ADDITIONAL REPORTING** • Care recipients assessed for significant unplanned weight loss **EXCLUSIONS** • 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 weight records available 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 or ongoing record relating to 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 (e.g. body fat or fluid), this weight loss will not be counted as unplanned weight loss, because it does not meet the definition.*

Significant unplanned weight loss is weight loss equal to or greater than 5% over a three month period. This is determined by comparing the last weight from the previous quarter and the last weight from the current quarter. Both these weights must be available to provide this result.

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

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*: Finishing weights for the previous quarter ('previous weight') and current quarter may have already been recorded for each care recipient as part of assessments and measurements made for consecutive unplanned weight loss. The same 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 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 bodyweight 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 who withheld consent to be weighed on the finishing weight collection date.
4. Record the care recipients who were not weighed because they are receiving end-of-life care.
5. Record the care recipients who were not assessed for significant unplanned weight loss because they did not have the required weight records. 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 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:

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

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 at the starting and/or finishing weight collection dates; or
- are receiving end-of-life care; or
- did not have a finishing weight recorded for the current and/or previous quarter/s;

are excluded from assessments for significant unplanned weight loss.

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.

1. **Number of care recipients assessed 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 a finishing weight recorded for the current or previous quarter. Include in the comments field the reason 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 current and previous quarter finishing weights.**

   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 the provider portal in order to make the information available to the Secretary.

10.6. How to record information in My Aged Care

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 My Aged Care.

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 Part B of this Manual.

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.

11.0 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 two categories within this quality indicator are:

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 aged care must collect and report on consecutive unplanned weight loss data quarterly, according to the requirements set out in this Manual.

TABLE 6: CONSECUTIVE UNPLANNED WEIGHT LOSS QUALITY INDICATOR OVERVIEW

Percentage of care recipients who experienced consecutive unplanned weight loss	**COLLECTION** • 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, to determine consecutive unplanned weight loss **QUALITY INDICATOR REPORTING** • Care recipients who experienced consecutive unplanned weight loss of any amount **ADDITIONAL REPORTING** • Care recipients assessed for consecutive unplanned weight loss **EXCLUSIONS** • Care recipients who withheld consent to be weighed at the starting, middle and/or finishing weight collection dates • Care recipients who are receiving end-of-life care • Care recipients who did not have their previous, starting, middle and/or finishing weight recorded 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 or ongoing record relating to 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 (e.g. body fat or fluid), this weight loss will not be counted as unplanned weight loss because it does not meet the definition.*

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 quarter finishing weight).

Starting weight is the weight recorded for each care recipient, in the first month of the quarter. The starting weight for significant and consecutive unplanned weight loss is the same weight collected at the same time, at the start 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 quarter. The finishing weight for significant and consecutive unplanned weight loss is the same weight collected at the same time, in the final month of the 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 relevant to indicating the quality of residential care in accordance with the requirements listed below.

Note*: Finishing weights for the previous quarter ('previous weight') and current quarter may have already been recorded for each care recipient 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.*

1. Using your service's weight records, identify each care recipient's 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 ask for care recipients' consent to assess their bodyweight 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 quarter, collect and record the finishing weight for each care recipient residing at the service, using a calibrated scale.

5. Record the care recipients who withheld consent to be weighed at the starting, middle and/or finishing weight collection dates.
6. Record the care recipients who were not weighed because they are receiving end-of-life care.
7. Record the care recipients who were not assessed for consecutive unplanned weight loss because they did not have a previous, starting, middle and/or finishing weight record/s. 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 compare the 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 at the starting, middle and/or finishing weight collection dates; or
- are receiving end-of-life care; or
- do not have a previous, starting, middle and/or finishing weight recorded;
- are excluded from assessments to determine whether there has been consecutive weight loss.

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.

1. **Number of care recipients assessed for consecutive unplanned weight loss.**
2. **Number of care recipients excluded because they withheld consent to be weighed at 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 for consecutive unplanned weight loss because they did not have a previous, starting, middle and/or finishing weight recorded, including comments as to why the weight recording/s are absent (e.g. the care recipient entered the service during the quarter).**
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 the provider portal in order to make the information available to the Secretary.

11.6. How to record information in My Aged Care

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 My Aged Care.

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 Part B of this Manual.

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.

12.0 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. 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 physiotherapy, via 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 fall risks and to have quality indicator monitoring of the results of interventions or programs in place for minimising falls.

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

TABLE 7: 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** • A single review of the care records of each care recipient for the entire quarter **QUALITY INDICATOR REPORTING** • Care recipients who experienced a fall (one or more) at the service during the quarter • Care recipients who experienced a fall (one or more) at the service resulting in major injury, or injuries, during the quarter **ADDITIONAL REPORTING** • Care recipients assessed for falls and major injury **EXCLUSIONS** • Care recipients who were absent from the service for the entire quarter

[5] RTI International. MDS 3.0 Quality Measures USER'S MANUAL. RTI International; 2019; Xu D, Kane R, Arling G. Relationship between nursing home quality indicators and potentially preventable hospitalisation. BMJ Qual Saf. 2019;28(7):524-33.

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] 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.

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]

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 three month assessment period.
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 who were absent from the service for the entire quarter (e.g. the care recipient was hospitalised for the entire three month period).
4. Record whether each care recipient experienced a fall (one or more) 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 a fall at the service, resulting in major injury (one or more), 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.

[6] World Health Organisation (2007), *WHO global report on falls prevention in older age*.
[7] RTI International. MDS 3.0 Quality Measures USER'S MANUAL. RTI International; 2019; Xu D, Kane R, Arling G. Relationship between nursing home quality indicators and potentially preventable hospitalisation. BMJ Qual Saf. 2019;28(7):524-33.

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.

1. **Number of care recipients whose records were assessed 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 a fall (one or more) at the service during the quarter.**
4. **Number of care recipients who experienced a fall at the service, resulting in major injury (one or more), 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 the provider portal 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 Part B of this Manual.

13.0 Medication management – polypharmacy

Medication management plays a critical role in achieving quality of care for older people in aged care and hospital settings. The two categories within this quality indicator are:

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 aged care must collect and report on polypharmacy data quarterly, according to the requirements set out in this Manual.

TABLE 8: MEDICATION MANAGEMENT – POLYPHARMACY QUALITY INDICATOR OVERVIEW

Percentage of care recipients who were prescribed nine or more medications	**COLLECTION** • A single review of medication charts and/or administration records for each care recipient on a selected collection date every quarter **QUALITY INDICATOR REPORTING** • Care recipients who were prescribed nine or more medications **ADDITIONAL REPORTING** • Care recipients assessed for polypharmacy • Collection date **EXCLUSIONS** • Care recipients admitted to 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, including complementary health care products, 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 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 who 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 a hospital admitted patient on the collection date.

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.

1. **The collection date for the quarter.**
2. **Number of care recipients assessed for polypharmacy.**
3. **Number of care recipients excluded because they were admitted to 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 the provider portal 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 Part B of this Manual.

14.0 Medication management – antipsychotics

Medication management plays a critical role in achieving quality of care for older people in aged care and hospital settings. The two categories within this quality indicator are:

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 the inappropriate use of certain medication classes, such as antipsychotics, has been shown to be associated with poor health outcomes. Approved providers of residential aged care must collect and report on antipsychotics data quarterly, according to the requirements set out in this Manual.

TABLE 9: MEDICATION MANAGEMENT – ANTIPSYCHOTICS QUALITY INDICATOR OVERVIEW

Percentage of care recipients who received antipsychotic medications	**COLLECTION** • A seven-day medication chart and/or administration record review for each care recipient every quarter **QUALITY INDICATOR REPORTING** • Care recipients who received an antipsychotic medication **ADDITIONAL REPORTING** • Care recipients assessed for antipsychotic medications • Care recipients who received an antipsychotic medication for a diagnosed condition of psychosis • Collection date **EXCLUSIONS** • Care recipients who were admitted to 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, including complementary health care products, 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 Part B of this Manual.

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 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 who were not included in the assessment due to hospital admission 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 admitted to hospital for the entire seven-day assessment period.

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.

1. **The collection date for the quarter.**
2. **Number of care recipients assessed for antipsychotic medications.**
3. **Number of care recipients excluded because they were admitted to 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 the provider portal in order to make the information available to the Secretary.

14.6. Additional resources for antipsychotics

More information and resources related to antipsychotic medication are available at www.health.gov.au and in Part B of this Manual.

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