Disclaimer

Inherent Limitations

This report has been prepared as outlined in the Introduction Section. The services provided in connection with this engagement comprise an advisory engagement which is not subject to Australian Auditing Standards or Australian Standards on Review or Assurance Engagements, and consequently no opinions or conclusions intended to convey assurance have been expressed.

No warranty of completeness, accuracy or reliability is given in relation to the statements and representations made by, and the information and documentation provided by, Department of Health personnel consulted as part of the process.

KPMG have indicated within this report the sources of the information provided. We have not sought to independently verify those sources unless otherwise noted within the report.

KPMG is under no obligation in any circumstance to update this report, in either oral or written form, for events occurring after the report has been issued in final form.

The findings in this report have been formed on the above basis.

Third Party Reliance

This report is solely for the purpose set out in the Introduction Section and for the Department of Health’s information, and is not to be used for any other purpose or distributed to any other party without KPMG’s prior written consent.

This report has been prepared at the request of the Department of Health in accordance with the terms of KPMG’s engagement contract. Other than our responsibility to the Department of Health, neither KPMG nor any member or employee of KPMG undertakes responsibility arising in any way from reliance placed by a third party on this report. Any reliance placed is that party’s sole responsibility.
1. **Introduction**

The National Aged Care Quality Indicator Programme (QI Programme) is a voluntary programme for aged care services.

Quality Indicators (QIs) measure aspects of service provision which contribute to the quality of care and services given by the provider, and to the consumers’ quality of life and experiences. The main objectives of the QI Programme are:

- To give consumers transparent, comparable information about quality in aged care to assist decision making.
- For providers to have robust, valid data to measure and monitor their performance and support continuous quality improvement.

The QI Programme is being implemented in a phased approach and will expand over time to encompass a range of QIs and quality of life and consumer experience measures in both home and residential aged care. QI data will ultimately be published on the My Aged Care website when the data has been established as reliable and accurate and after stakeholder consultation.

As part of the first phase of the programme, three initial QIs were piloted between May and September 2015 with approximately 350 residential aged care facilities (RACFs). This included a nationally representative sample of 160 RACFs. KPMG were engaged by the Department of Health (the Department) to undertake a pilot of quality indicators within approved residential aged care facilities across Australia. KPMG were responsible for planning, delivery and review of the pilot.

The pilot aimed to examine:

- the nature of data capture and data collection learning processes
- accessibility and usefulness of pilot support materials
- additional support/assistance requirements
- format of the individual report for summarising facility results
- pathways for implementation and reflections for consideration in development of the QI Programme.

2. **Overview of the pilot process**

The pilot process was progressed over three main stages:

- Pilot planning and preparation – The development of the pilot infrastructure and environment, including written resources and communication products; online surveys and data recording sheets; a participant website; and an electronic data submission tool.

- Pilot delivery – This involved pilot recruitment, orientation sessions and collection of quality indicator information. A structured process of collection, analysis and reporting of quality indicator information was implemented. This was undertaken from May to September 2015.

- Pilot feedback and close – A feedback process was conducted which enabled RACFs and service providers to offer feedback, share experiences and offer suggestions. This involved
electronic feedback surveys and service provider roundtable meetings. The pilot scope details, specifically the inclusions and exclusions, are outlined below.

**Table 1: Pilot scope**

<table>
<thead>
<tr>
<th>Pilot Inclusions</th>
<th>Pilot Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Identification of a nationally representative sample of core facilities.</td>
<td>• Development or assessment of the technical validity or reliability of existing quality indicators.</td>
</tr>
<tr>
<td>• Development of resource material, and provision of orientation, outbound coaching (for the core sample) and support for pilot participants.</td>
<td>• Modification or adaptation of the quality indicators and materials copyrighted by the Victorian Department of Health and Human Services.</td>
</tr>
<tr>
<td>• Conduct of feedback processes with pilot participants.</td>
<td>• Outbound coaching of non-core sample (general support provided).</td>
</tr>
<tr>
<td>• Piloting of three quality indicators, as defined by the Victorian Public Sector Residential Aged Care Services Quality Indicator Programme over two data collection cycles.</td>
<td></td>
</tr>
<tr>
<td>• Compilation of learnings and implications for programme commencement.</td>
<td></td>
</tr>
</tbody>
</table>

*Source: KPMG*

### 3. Summary of pilot participation

In pilot cycle one, 404 facilities indicated they would participate; and in pilot cycle two, 433 facilities indicated they would participate.

Of these facilities, 299 submitted data on time in pilot cycle one, and 292 submitted data on time in pilot cycle two.

Overall, there were 345 residential aged care facilities that participated in the pilot nationally over the two pilot data collection cycles. KPMG analysed the data and prepared an individual report of each facility’s results, which was provided to the facilities.

Based on participating facilities, over 20,000 residents were involved in the pilot.

**Table 2: Participating facilities**

<table>
<thead>
<tr>
<th>Summary</th>
<th>Pilot Cycle One</th>
<th>Pilot Cycle Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilities agreeing to participate</td>
<td>404</td>
<td>433</td>
</tr>
<tr>
<td>Facilities that submitted data on time</td>
<td>299</td>
<td>292</td>
</tr>
<tr>
<td>Facilities that submitted data (percentage of facilities agreeing to participate)</td>
<td>74.0%</td>
<td>67.4%</td>
</tr>
<tr>
<td>Total facilities in Australia</td>
<td>2,764</td>
<td>2,764</td>
</tr>
<tr>
<td>Facilities that submitted data (percentage of total facilities in Australia)</td>
<td>10.8%</td>
<td>10.6%</td>
</tr>
</tbody>
</table>

*Source: KPMG*

Appendix 1 provides additional details on pilot participation.
4. **Summary of support**

- One hundred forty-five facility representatives participated in the orientation sessions that were held in May 2015 in metropolitan locations nationally and via teleconference.

- One hundred forty-four facility and service provider representatives participated in the service provider round table sessions that were held in October 2015 in metropolitan locations nationally and via teleconference.

- Over the course of the pilot, 926 calls were received by the pilot help hotline.
  - The volume of telephone calls received on the hotline varied during different stages of the pilot. Calls were generally of a higher volume during the first pilot cycle.
  - Within the two pilot cycles, the highest volume of calls were received in the first two weeks of the pilot, and then during the week of data submission (approximately 15 to 20 calls per day).
  - Midway through the two pilot cycles, during weeks 3 and 4, the hotline received very few calls.
  - Across the pilot, approximately 30 calls were clinically-related calls that were escalated to the KPMG clinicians.
  - Across the pilot, approximately 180 calls were related to the quality indicators, and were answered by the hotline staff by referencing the Pilot Handbook or the Commonly Asked Questions.
  - Calls lasted between approximately 30 seconds to seven minutes in length, depending on the nature of the enquiry.

- Over the course of the pilot, over 2,283 emails were received by KPMG. Estimates of the distribution of the reason for the email are outlined below.

<table>
<thead>
<tr>
<th>Reason for the email – facility initiated contact</th>
<th>% of emails</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilot registration and initial expressions of interest</td>
<td>49.0%</td>
</tr>
<tr>
<td>Pilot cycle one (e.g. change contact details, withdraw)</td>
<td>22.5%</td>
</tr>
<tr>
<td>Data submission pilot cycle one</td>
<td>15.0%</td>
</tr>
<tr>
<td>Focus group/consultation inquiries</td>
<td>1.8%</td>
</tr>
<tr>
<td>Clinical inquiries</td>
<td>0.3%</td>
</tr>
<tr>
<td>Pilot cycle two general inquiries (e.g. change contact details)</td>
<td>11.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

*Source: KPMG*
5. Summary of quality indicator results

As anticipated during the pilot planning and design, there are limitations on the extent to which the quality indicator data gathered during the pilot can be considered accurate or be relied upon. The pilot was designed to trial collection and reporting processes only, using truncated collection cycles. Participants were advised that the resulting quality indicator data would be of limited value.

Instances of issues with the data included submission errors related to facility/individual unit identification, incorrect applications of quality indicator definitions (such as the inclusion of residents in the data collection process that should have been excluded), and incorrect data submitted into the data submission (e.g. data entered against the wrong indicator).

In light of this, as pilot participants and stakeholders were advised prior to the pilot, all quality indicator data should be acknowledged as pilot data only. It should also be noted that, as a minimum of three collection cycles are necessary for trends to be observed, no trends can be identified from the two collection cycles of the pilot.

5.1 Pressure injuries

Observations:

- Most facilities were able to collect and report the pressure injuries indicator.
- This indicator was acknowledged as resource intensive to administer in light of the time required to undertake a full body assessment. The size of residential aged care facilities will have implications for the resource commitment required.
- There was some feedback on the need for greater clarity on the requisite skills and experience of those that undertook the full body assessment.
- There were concerns on the reporting of pressure injuries that were attributed to other providers or settings (e.g. new pressure injuries identified following a hospital admission). However, there was acceptance of the value in counting changes in staging of pressure injuries over time (e.g. the change from pressure injury stage four to three over data collection cycles) which were attributed to facility care practices.
- Common questions raised by participants include:
  - **Are skin tears (in the presence and absence of a pressure wound) counted in this measure?**
  - **Are you providing an assessment tool for facilities to use to conduct full-body assessments of residents?**
  - **Are you specifying what level of qualification is required for staff conducting full-body assessments?**
  - **How can I indicate where a pressure injury was present on admission? Why is this pressure injury still reflected in my facility’s data?**
5.2 Use of physical restraint

Observations:

- Most facilities were able to collect and report the use of the physical restraint indicator.
- This indicator received the most enquiries relating to the interpretation of the indicator definitions. This highlights the need for further support for some facilities to ensure a common understanding of and approach to the use of physical restraint indicator.
- The conduct of an observational audit undertaken at morning, afternoon and evening shifts had implications for facility approach, given that there was a potential need for additional staff to be trained to participate in the data collection process (e.g. night shift staff).
- Common questions raised by participants include:
  - How do we score a resident who is no longer mobile in a recliner chair/floor line mattress/hi lo bed?
  - How do we score a resident who has multiple restraints in place (e.g. a resident is on a floor line bed, on a concave mattress and has bed rails in place)? Is the intent to restrain scored 1 or more?
  - How should bedrails be counted? E.g. are two bedrails counted as two restraint devices or one? What about if the bedrails are raised at the request of the resident or their family?
  - If a person does not have freedom of movement and is placed in a princess chair for comfort rather than intent to restrain, would this only be considered a device and not intent?
  - Does a locked room or a locked facility count as restraint?

5.3 Unplanned weight loss

Observations:

- Most facilities were able to collect and report the unplanned weight loss indicator, even with the shorter collection cycle (six weeks vs. 12 weeks).
- In light of existing arrangements, some facilities had challenges adjusting existing processes to the six week pilot cycle. Some facilities also noted the challenge of weighing residents under similar conditions (e.g. wearing similar clothes or at the same time of day) across two points during the cycle.
- There was some feedback on the appropriateness of this indicator’s definition over alternative measures such as percentage of total weight loss and percentage change in body mass index.
- A common question raised by participants include:
  - What should I do if I can’t measure a resident’s weight exactly four weeks apart (e.g. their weight is measured a few days late)?
6. Unintended clinical practice changes arising from the pilot

The pilot process was framed to demonstrate the feasibility of the collection, submission and reporting of quality indicator information within facilities. As a result, the two pilot cycles were not explicitly designed to place emphasis on local quality improvement efforts or to support consumer awareness, choice and decision-making. However, the pilot identified a number of examples from facilities which demonstrate how the process and information was used by facilities to implement service improvement changes. These included the following:

- **The development and adoption of a range of local resources to formalise and systematise processes** – This included the use of nursing anatomical checklists to facilitate full body assessments, including the complementary use of digital cameras to facilitate monitoring of pressure injuries and other clinical issues.

- **The purchase and use of equipment to reduce the use of physical restraint** – There were facilities that invested in the purchase of low-low beds in response to the focus on intention to use physical restraint and use of devices.

- **The review of organisational policies relating to physical restraint** – Some facilities took the opportunity to develop, review or update local physical restraint policies in light of the local and national focus on use of physical restraints as part of the pilot. The implementation of the policies and the realisation of clinical practice and cultural change will take some time to occur; however, this is an important step.

- **There were also a range of clinical issues that were identified as part of the conduct of full body assessments that were outside of the scope of the quality indicators** – Some facilities acknowledged that the conduct of the full body assessment provided a mechanism for the opportunistic screening and identification of clinical issues beyond the scope of pressure injuries. One facility noted that this included the identification of basal cell carcinomas (skin cancers), whereby identification from the full body assessment allowed for the resident to be placed on a treatment and care pathway in a timely manner.

These examples demonstrate that there were a range of intended and unintended benefits derived from the pilot which relate to the programme purpose of supporting local quality improvement efforts. These examples provided important insights into the value of the programme from a resident, facility/service provider, and system perspective. These examples can be shared as local success stories to highlight some of the benefits that can be derived from participating in the programme using the national definitions and approach.

7. Pilot Feedback

A pilot feedback process was undertaken following the completion of pilot cycles one and two. This included the following:

- **The conduct of service provider round tables (six) that were held face-to-face in selected states and territories and via teleconference**. This sought to facilitate debriefing and discussion of RACF experiences.
• The distribution of feedback surveys following the completion of pilot cycles. These surveys were conducted online and focused on the pilot resources, processes and systems. The survey was designed to be completed by the primary contact person at each participating RACF or service provider.

Key themes emerging from the service provider consultation process include the following:

_Pilot requirements relative to existing arrangements_

• Facilities advised that RACFs were already collecting some, if not all, data around weight loss, pressure injuries or restraint.

• Facilities noted the definitions and collection requirements for pressure injuries were over and above their usual practice.

• Participants were generally split in regards to the difficulty of data collection. Some participants indicated that data collection was resource and time intensive whilst others reported that the RACF already collect quality indicator data, hence, the collation and submission process was not considered onerous.

• Facilities stated that if data collection is integrated into existing processes and systems, it will make it easier for providers to collect and collate data and will also ensure that the duplication of data is avoided.

_Quality indicator definitions and methodology_

• Participants expressed interest in expanding the suite of quality indicators. Potential quality indicators included falls, infections and use of chemical restraint.

• Participants agreed that there needs to be clear and consistent understanding of the quality indicator definitions, and application within the clinical context. Clearer advice on the application of the physical restraint definitions in the clinical context would be helpful in order to avoid misinterpretation. These were considered key to sustaining involvement.

• Some facilities stated that there needs to be consideration around the challenges of staff turnover and staff resourcing in general. These factors will impact the level of consistency of data collections.

_Quality indicator information_

• There is value in building the capacity to enable providers to examine results relative to comparable peers. This means that there is a need to develop a clear and consistent way to classify facilities. Benchmarking is vital, but only if it is against similar facilities.

• For consumers accessing publically reported quality indicator information, the data should acknowledge the differences between facilities, so that users are able to view the results with adequate context.

• There is a need to emphasise the use of the data for the purposes of local quality improvement. This should involve clear identification and communication of the benefits for participation. It is not advisable to assume that facilities will know how to use the data.

• Some providers expressed that participating in the programme could be used to better promote and market services to consumers. This is a good and important aspect of this voluntary initiative.
Pilot coaching, support and resources

- Participants commented on the helpful nature of the pilot hotline and email address. The ability for providers to raise questions and receive prompt responses with a reassuring nature of the coaches, greatly assisted in the pilot.

- Participants from the roundtables indicated a strong preference to receive emails outlining key updates with direct links to the information that needs to be accessed.

Pilot and Programme participation

- There were a number of facilities where participation was driven by the chief executive officer. As such, at the staff level, there is a need to ensure there is value in data.

- Some participants noted that there is a perception that participating in the programme is seen as a burden. In addition, a lack of time or resources may have potentially prevented participation. This needs to be carefully communicated and strategies instituted for minimising the perceived burden for RACFs.

Attitudinal survey question

The pilot surveys sought to assess participant attitudes in relation to the benefit of the quality indicators and initiative. The question was posed three times:

1. Pre data submission (stand-alone question)
2. Feedback for cycle one (part of larger survey)
3. Feedback for cycle two (part of larger survey)

The surveys asked respondents to indicate the extent to which they agree with the following statement:

At this point in time, I consider that collection, analysis and use of quality indicator data through the National Aged Care Quality Indicator pilot will make a positive difference for residents in this residential aged care facility.

Seventy-seven per cent of RACFs that responded to the initial attitudinal survey agreed or strongly agreed that the pilot would have a positive impact for their residents. Following this, 62 per cent of RACFs responded for the second time this indicator was collected. The third and final time this measure was collected, 61 per cent of RACFs agreed or strongly agreed.

Key insights and learnings

- Quality indicator data was collected in a range of contexts and settings with different staffing arrangements, staff learning preferences, information technology, experience with collection and analysis of quality indicators.

- A range of pilot resources were developed, including a Pilot Handbook to guide participants through the process.

- The pilot identified that there is a sound level of programme readiness among the residential aged care sector, from a system, process, workforce and value perspective.
Quality indicator data provided the opportunity to assess what kind of statistical analysis would be appropriate. This included the statistical approaches and depth of analysis required to incentivise participation, and ensure the technical credibility of the information reported.

The main feedback on the quality indicator reports provided to facilities related to the aggregate result. There is potential to further enhance this, such as through the inclusion of aggregate results which add details of multiple facility results within the same service provider and from a range of potential peers (e.g. aggregates at the national, jurisdictional, and geographical levels, and peers at comparable size and configuration).

**Overall pilot findings and conclusions**

With due consideration of the pilot purpose and objectives, it was found that:

- Pilot support (which comprised orientation, openly accessible written information, proactive coaching/outbound support, timely clinical and generalist inbound support) provided a sound pilot model. Feedback suggested that, overall, this approach facilitated the planning and conduct of the pilot at the facility level. The effectiveness of the outbound and inbound support model is especially important in a new programme.

- The three piloted quality indicators are relevant for implementation based on the literature and evidence. The quality indicators were applicable at a national level and collection was feasible across a range of facility types. The highest number of inbound clinical queries related to definitions associated with the use of physical restraint.

- There is a level of variation at the facility level which influences the capacity to implement the indicators as part of standard practice. This includes the extent to which collection requirements may be new (such as the conduct of observational audits for use of physical restraint), may vary from existing quality practices (quality indicator definitions) and the value and investment in local data collection practices and resultant datasets which can influence perceptions of the pilot approach. This includes the links between the Victorian Department of Health and Human Services public sector Residential Aged Care Services Programme and the national programme.

Informed by the pilot findings, observations and learnings, it is concluded that:

- The collection, electronic submission, analysis and reporting of quality indicator information is feasible at a national level.
Appendix 1: Pilot Participation

In total, 299 facilities submitted data for pilot cycle one and 292 facilities submitted data for pilot cycle two. Provided below are a breakdown of the number of facilities that submitted data by state and remoteness. As would be expected, the distribution of those facilities that submitted data generally matches the population distribution of facilities. For example, most facilities are in NSW and Victoria, and these two jurisdictions had the most facilities that submitted data. This is similar when looking at remoteness.

Table 4: Participating facilities by location and pilot cycle

<table>
<thead>
<tr>
<th>State</th>
<th>Pilot Cycle One</th>
<th>Pilot Cycle Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW/ACT</td>
<td>86</td>
<td>84</td>
</tr>
<tr>
<td>VIC/TAS</td>
<td>92</td>
<td>99</td>
</tr>
<tr>
<td>QLD</td>
<td>39</td>
<td>38</td>
</tr>
<tr>
<td>WA</td>
<td>29</td>
<td>30</td>
</tr>
<tr>
<td>SA</td>
<td>53</td>
<td>41</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>299</strong></td>
<td><strong>292</strong></td>
</tr>
</tbody>
</table>

Source: KPMG

Table 5: Participating facilities by remoteness and pilot cycle

<table>
<thead>
<tr>
<th>Remoteness</th>
<th>Pilot Cycle One</th>
<th>Pilot Cycle Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Cities of Australia</td>
<td>188</td>
<td>185</td>
</tr>
<tr>
<td>Inner Regional Australia</td>
<td>88</td>
<td>76</td>
</tr>
<tr>
<td>Outer Regional and Remote Australia</td>
<td>23</td>
<td>31</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>299</strong></td>
<td><strong>292</strong></td>
</tr>
</tbody>
</table>

Source: KPMG

Table 6: Participating facilities by organisational type and pilot cycle

<table>
<thead>
<tr>
<th>Organisational type</th>
<th>Pilot Cycle One</th>
<th>Pilot Cycle Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religious</td>
<td>94</td>
<td>87</td>
</tr>
<tr>
<td>Charitable</td>
<td>73</td>
<td>67</td>
</tr>
<tr>
<td>Community Based</td>
<td>55</td>
<td>62</td>
</tr>
<tr>
<td>Private Incorporated Body</td>
<td>53</td>
<td>50</td>
</tr>
<tr>
<td>State Government</td>
<td>24</td>
<td>26</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>299</strong></td>
<td><strong>292</strong></td>
</tr>
</tbody>
</table>

Source: KPMG