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Disclaimer

This publication and all its component parts are provided to assist residential aged care facilities administer the voluntary National Aged Care Quality Indicator Program (QI Program).

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Do you need assistance?

The Australian Government Department of Health would like to encourage you to review the support materials and talk to colleagues to resolve any questions in the first instance.

If this does not assist in resolving the concern, please contact the My Aged Care provider and assessor helpline on 1800 836 799. The helpline will be available between 8am to 8pm Monday to Friday and 10am to 2pm Saturday, local time across Australia. Please note that any clinical questions may require referral to clinical specialists.
PART A: Handbook for residential aged care facilities

1. Introduction to the National Aged Care Quality Indicator Program

1.1 Overview

The National Aged Care Quality Indicator Program (QI Program) is a voluntary Program for aged care services. The overall objectives of the QI Program are that:

- Consumers will have access to transparent, comparable information about quality in aged care. This will facilitate more informed choices by consumers when information about quality indicators (QIs) and the results from the QIs are published on the My Aged Care website.
- Providers will have robust, valid data to support continuous quality improvement in the care provided to residents.

The QI Program is commencing in residential aged care facilities and will expand over time to encompass home care services. The objective of the residential aged care component of the QI Program is to introduce a set of evidence based QIs into Commonwealth subsidised residential aged care facilities (residential facilities). The QIs focus on the quality of care residents are receiving. The QI Program will enable your residential facility to measure and monitor performance in the QI areas of care and to use this information in your continuous quality improvement activities.

The QI Program will:

- Provide a set of meaningful and measurable QIs to assist residential facilities to monitor and improve important aspects related to quality of care.
- Enhance community understanding of quality in residential aged care through the publication of information on the My Aged Care website about the quality of care reported by services.
- Provide more information to consumers to assist with choices and decision making about residential aged care services.
- Enable residential facilities to monitor and identify trends in their performance over time, compare with other facilities and implement improvements that will promote quality of care and quality of life.
- Provide nationally comparable QI data across residential facilities in Australia (for the first time).
- Improve local capacity to strengthen clinical governance.
- Develop an evidence base to facilitate quality improvement initiatives.

The QI Program was piloted in 2015 in residential facilities, and national implementation in residential facilities commenced in 2016. This resource manual is designed specifically for residential facilities.
1.2 Why are QIs being introduced into aged care facilities?

The Productivity Commission (2011) report, Caring for Older Australians, and the Australian National Audit Office (2011) report, Monitoring and Compliance Arrangements Supporting Quality of Care in Residential Aged Care Homes, recommended that QIs be developed for aged care.

In line with aged care reforms, information on QIs for residential facilities and home care will, over time, be published on the My Aged Care website. This will give consumers additional information about the quality of care and quality of life and help them make decisions about care options.

It is likely that your residential facility already measures the quality of care you provide to residents to assist continuous quality improvement. The QI Program will complement the processes you already use and enable more targeted and evidence based continuous quality improvement.

1.3 How will information from the QI Program be collected and managed?

The methods of data collection and management for the QI Program are likely to differ from the methods you currently use. The QI Program involves specific methods for collecting, recording, submitting and interpreting information about the QIs. It is important for the reliability of the QI Program that you use the methods exactly as described in this resource manual.

To participate in the QI Program you will record and submit your QI data into the My Aged Care Provider Portal (the Provider Portal).

The Provider Portal is designed to:

- Capture, process and display information from residential facilities about quality of care.
- Provide reports to residential facilities in relation to quality of care.
- Enable data to be published on My Aged Care once the data from the QI Program is established as valid, consistent and reliable.

Your residential facility will be able to interpret raw QI data and related reports and use this information to influence quality of care and implement continuous quality improvement. Suggestions about how to do this are outlined in Chapter 8: Using information from the quality indicators for quality improvement.
2. Understanding Quality Indicators and those in the National Aged Care Quality Indicator Program

2.1 Introduction

Quality Indicators (QIs) and QI Programs aim to improve the quality of care consumers receive.

Quality Indicator programs are already used in Victorian public sector residential aged care services and in aged care services in many other countries, such as the United States, Korea, United Kingdom and the Netherlands. The National Aged Care Quality Indicator Program (QI Program) is building on significant work already undertaken in this area.


2.2 What are QIs and what is their role?

QIs are defined measures that relate to the assessment of care. There are many definitions for QIs. Most definitions identify that a QI is ‘a tool to help us identify performance issues, flag concerns and prompt us to make improvements to care’ (Arora et al. 2007).

Some definitions also align with how the QIs are used in the QI Program, for example:

- A tool within a broader quality system that assists us to describe and communicate what we mean by high quality care.
- A tool to assist us to set goals and monitor if we are achieving them.
- A tool within the quality governance systems with results used to inform boards and executives about performance in care.

It is important to note that QIs do not provide data for making instant judgements about quality of care. As their name suggests, they are an indicator only. The information obtained from QIs can alert us to situations that require further investigation. For example:

- Information from QIs may identify trends that suggest changes to quality of care over time.
- Information from QIs can identify the possibility of a problem or improvement that occurred during a specific time period.
- A less than optimal performance in a specific QI does not necessarily mean an organisation has a poor quality system or substandard care practices. It may be due to data collection methods or unexpected one-off events.

So it is essential to understand that the information from QIs is to be used as a basis for further investigation – to understand factors in care provision – and not as the sole basis for taking action or making changes to care practices.

More information is available at Appendix 1: Quality Indicators.
2.3 The QIs in the QI Program – residential care

2.3.1 The indicators

The QI Program involves collecting data for three QIs (currently) that address important aspects of quality of care in clinical areas. Each of these indicators has a number of measures that together total 10 measures in relation to the quality of care. The quality of care indicators and their measures used in the QI Program for residential care are:

1: Pressure injuries
   - There are six measures: Stage 1 pressure injuries, Stage 2 pressure injuries, Stage 3 pressure injuries, Stage 4 pressure injuries, Unstageable pressure injuries and Suspected deep tissue injuries.

2: Use of physical restraint
   - There are two measures: Intent to restrain and Use of physical restraint devices

3: Unplanned weight loss
   - There are two measures: Significant unplanned weight loss and Consecutive weight loss.

2.3.2 Evidence based indicators

The above QIs are drawn from the Victorian QI program referenced above. The Victorian QI program commenced development in 2003 and was implemented in 2006. It has been evaluated, reviewed and revised by technical experts since implementation.

The QIs used in the QI Program are based on evidence and the reliability and validity of them has been established. Reliable and valid definitions, data sources and methods for collecting, recording and submitting data are central to providing useful information. Boards, executives, managers, staff, residents and their families need to have confidence that the QI data is accurate.

Residential facilities participating in the QI Program will collect data in relation to each QI and enter the data on the My Aged Care Provider Portal (the Provider Portal).\(^1\) It is integral to the QI Program that all participants collect and enter their data consistently as described in this resource manual. This will ensure the information from the QI Program is reliable and valid which will enable the use of the information for quality improvement including comparing information from the QIs across residential facilities.

The following chapters provide guidance on participating in the QI Program.

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\(^1\) This may vary for Victorian public sector residential aged care services.
3. Glossary of terms, timelines and processes for participation in the National Aged Care Quality Indicator Program

3.1 Glossary of terms

Residential facility
A Commonwealth subsidised residential aged care facility.

Resident
A person living in a residential facility.

Consumer
Resident, carer, family, friend or interested community member.

Quality of care
At a broad level, quality of care refers to the extent to which an organisation can produce the desired outcomes for care. Quality of care consists of a range of dimensions such as the safety, appropriateness, effectiveness, responsiveness, continuity, sustainability, accessibility and capacity of care and services.

Raw Quality Indicator (QI) data for the quality of care indicators
The number of occurrences counted and recorded for each of the 10 measures for the three quality of care indicators in each quarter. Specifically,

1: Pressure injuries
2: Physical restraint, and
3: Unplanned weight loss.

Occupied bed days (OBD)
The number of days in care in the subsidy claiming system. The QI rate is calculated from the data submitted by residential facilities through the subsidy claiming system. Therefore, the QI rate cannot be calculated until the Australian Government Department of Health (the department) receives the OBD information for each residential facility.

QI rate for the quality of care indicators
The rate for each of the quality of care indicators is a rate per 1000 OBD. The rate is derived using the following formula:

\[
\text{Quality of care indicator rate} = \frac{\text{Raw number of the measure being controlled}}{\text{OBD for the quarter}} \times 1000
\]

Using the rate per 1000 OBD means residential facilities of different sizes can compare their performance.
**Palliative care approach and end-life-care**

**Palliative care**

‘When the resident’s condition is not amenable to cure and the symptoms of the disease require effective symptom management, a palliative approach is appropriate. Providing active treatment for the resident’s disease may also still be important and may be provided concurrently with a palliative approach. However, the primary goal of a palliative approach is to improve the resident’s level of comfort and function, and to address their psychological, spiritual and social needs.’ (Australian Government & National Health and Medical Research Council 2006).

**End-of-life (terminal) care**

‘This form of palliative care is appropriate when the resident is in the final days or weeks of life and care decisions may need to be reviewed more frequently. Goals are more sharply focused on the resident’s physical emotional and spiritual comfort, and support for the family.’ (Australian Government & National Health and Medical Research Council 2006).

### 3.2 Timeframes and processes

Participants in the National Aged Care Quality Indicator Program (QI Program) will collect raw QI data and enter it via the QI section of the My Aged Care Provider Portal (the Provider Portal). Data is collected quarterly and is based on the financial year calendar.

The cut-off date for data submission for the quality of care indicators is the 21st day of the month after the end of each quarter. This is for:

1: Pressure injuries
2: Physical restraint
3: Unplanned weight loss.

So the QI raw data for these indicators needs to be entered, based on the financial year calendar, no later than:

- Quarter 1 (1 July to 30 September) – 21 October
- Quarter 2 (1 October to 31 December) – 21 January
- Quarter 3 (1 January to 31 March) – 21 April
- Quarter 4 (1 April to 30 June) – 21 July

The Provider Portal will use the raw QI data to produce reports for each residential facility. Residential facilities will be able to access these reports through the Provider Portal. Reports with the previous quarter’s data included will be available one month after the end of each quarter.

A diagrammatic overview of the processes for residential facilities in relation to data collection, submission and reporting for the QI Program is presented in Figure 1, and Appendix 2 provides an example template for scheduling QI data collection.
Figure 1: Overview of the timeframes and processes for residential facilities to manage Quality Indicator data for the National Aged Care Quality Indicator Program

Collect and record Quality Indicator data

Only staff who have a thorough knowledge of the definitions and methods for collecting and recording the Quality Indicator data and comments should collect and record this data.

1. Pressure injuries
   - Count all
   - Stage 1
   - Stage 2
   - Stage 3
   - Stage 4
   - Unstageable
   - Suspected deep tissue injuries.
   Undertake a full body assessment of every resident, including respite residents, each quarter

2. Use of physical restraint
   - Count all
   - Occurrences where a resident is physically restrained
   - Physical restraint devices. Do not count secure areas and perimeter alarms as restraint for this indicator.
   Conduct three observational assessments on all residents on three separate days in a quarter

3. Unplanned weight loss
   - Count residents with
   - Any unplanned weight loss each month over three consecutive months
   - Significant unplanned weight loss (≥3 kg) over three months.
   Weigh each resident monthly except for residents who are absent, residents receiving end-of-life palliative care, and respite residents.

Record the Quality Indicator data and relevant comments from the assessment of each resident on your facility’s Quality Indicator data collection and recording sheet.

Summarise the Quality Indicator data

Calculate the total for the Quality Indicator data for each indicator from your records and summarise the comments.

Submit the summarised Quality Indicator data

Submit the summarised Quality Indicator data for each indicator, consisting of the totals for each indicator and the summarised comments, to the My Aged Care Provider Portal by the cut-off dates:
   - Quarter 1: 21 October
   - Quarter 2: 21 January
   - Quarter 3: 21 April
   - Quarter 4: 21 July

Access Quality Indicator reports

Access the Quality Indicator reports via the My Aged Care Provider Portal. The previous quarter’s reports will be available one month after the end of the quarter.
4. Quality Indicator 1: Pressure injuries

4.1 Objective
To monitor the proportion of pressure injuries and trends.

4.2 Why monitoring pressure injuries is important
Older people are more susceptible to pressure injuries. This continues to be a major and prevalent health concern.

Even though most pressure injuries are preventable, evidence shows that up to 42 per cent of people who live in residential aged care facilities may have a pressure injury. Seventy per cent of pressure injuries occur in people over 70 years of age.

Pressure injuries can develop as a result of:
- friction and shearing forces
- aged-related changes to skin
- medication-related changes to the skin
- poor nutrition
- decreased mobility
- chronic disease
- incontinence
- restraint.

Common adverse events associated with pressure injuries include:
- death
- infection and cellulitis
- reduced physical function
- pain.

4.3 Key facts
- The risk of developing a pressure injury increases as a result of age-related changes such as changes to skin integrity, malnutrition, immobility, incontinence, impaired cognitive status and frailty.
- From 2001–03 in Australia, 923 deaths occurred as a result of pressure injury.
- Infection occurring in a pressure injury is associated with death.
4.4 How to collect and report this indicator

4.4.1 Measures and data collection

To collect data for this Quality Indicator (QI), every resident will be assessed for pressure injuries once each quarter.

There are six measures to be collected in relation to pressure injuries:

- Stage 1 pressure injuries
- Stage 2 pressure injuries
- Stage 3 pressure injuries
- Stage 4 pressure injuries
- Unstageable pressure injuries
- Suspected deep tissue injuries.

First, tell the resident about the proposed assessment and ask for their permission. If they withhold permission, note this in the comments section of your data recording sheet.

Collect data by doing a full-body assessment of the resident. Where possible, do this as part of the resident’s usual personal care.

The assessment can be conducted either by assessing every resident over a set period of up to 14 days, or by identifying an assessment date for each resident and completing the assessment on the same day each quarter.

Record all observed pressure injuries.


Use the international classification system consistently and for all residents assessed.

If you are uncertain about the presence and stage of a pressure injury, consult with a suitably qualified practitioner.

4.4.2 Comments section on the data recording sheet

Include the following in the comments section on your data recording sheet:

- Note any residents admitted during the current reporting quarter, where injuries were present on admission and include in the count.
- In subsequent quarters, include these injuries in the ordinary count – no comment needed.
  - The above note also applies to respite residents.
- Note if the pressure injury developed while the resident was away from the residential facility, for example, while in hospital.
- Note where the pressure injury relates to a resident receiving end-of-life palliative care.

4.4.3 Exclusions

Nil.
4.4.4 Inclusions
Make sure you include respite residents.

4.4.5 Quick tips for data accuracy

- Collect information for the pressure injury measures through actual observation on or around the same time/date in each quarter.
- Ensure information is collected consistently. For example, two staff members independently observing a resident with a pressure injury must both correctly identify the stage of the pressure injury and report it in the same way.
- Collect information exactly as described in this resource manual. Do not use information from existing data sets that you may have, e.g. incident reporting systems, where information has been collected differently to what is described in this resource manual.

4.5 Definitions for Quality Indicator 1: 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 (AWMA 2012; AWMA 2014; National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance 2014).

Previous terms used include pressure ulcer, bed sore and decubitus ulcer. In Australia, as part of the Pan Pacific region, the term pressure injury has been adopted and should be used.

4.5.1 International classification system for pressure injuries

Stage 1 pressure injury: non-blanchable erythema

- Observable pressure-related alteration of intact skin whose indicators as compared with the adjacent or opposite area of the body may include changes in one or more of the following: non-blanchable redness of a localised area usually over a bony prominence.
- Discolouration and visible blanching may not be seen in people with darkly pigmented skin, and the colour of this pressure injury may differ from the surrounding area.
- The area may be painful, firm, soft, warmer or cooler compared with adjacent tissue.
- It may indicate an at-risk individual: someone who marks very quickly. It is a sign of risk.
- Note: it is easy to confuse reactive hyperaemia – skin discolouration – with a stage 1 pressure injury.
- Reactive hyperaemia is a normal compensatory mechanism following an episode of reduced perfusion from localised pressure. Relief of this pressure results in a large and sudden increase in blood flow to the affected tissue.
- Residents who have an area of reactive hyperaemia need to be repositioned off the affected area; re-inspect the skin 30 minutes later for evidence of a stage 1 pressure injury.
Stage 2 pressure injury: partial-thickness skin loss

- Partial-thickness loss of dermis presenting as a shallow, open wound with a red-pink wound bed, without slough.
- It may also present as an intact or open/ruptured serum-filled blister.
- It may present as a shiny or dry shallow injury without slough or bruising (note: bruising indicates suspected deep-tissue injury).
- Do not describe skin tears, tape burns, perineal dermatitis, maceration or excoriation as stage 2 pressure injuries.
Stage 3 pressure injury: full-thickness skin loss

- Full-thickness tissue loss where subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of the tissue loss. May include tunnelling and undermining.
- The depth of a stage 3 pressure injury varies by anatomical location and general skin condition. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage 3 pressure injuries can be shallow. In severely malnourished residents the lack of subcutaneous tissue will also mean a stage 3 pressure injury may present as a shallow injury.
- Bone or tendon is not visible or directly palpable.

Stage 4 pressure injury: full-thickness tissue loss

- Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed.
- The depth of a stage 4 injury varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these pressure injuries can be shallow. Stage 4 pressure injuries can also extend into other supporting structures (such as fascia, tendon or joint capsule) making osteomyelitis a serious consideration.
- Exposed bone or tendon is visible or directly palpable.
Unstageable pressure injury: depth unknown

- This presents as full thickness tissue loss in which the base of the pressure injury is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the pressure injury bed.
- Until enough slough or eschar has been removed to expose the base of the wound, the true depth, and therefore the stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on heels serves as the body’s natural biological cover and should not be removed.

Suspected deep-tissue injury: depth unknown

- This is a purple or maroon localised area or 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 compared with adjacent tissue.
- This deep tissue pressure injury may be difficult to detect in individuals with dark skin tone.
- Evolution may include a thin blister over a dark wound bed. The injury may further involve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.
4.6 Quality Indicator 1: Pressure injuries – processes for managing QI data

As outlined in Chapter 3, Figure 1, the processes associated with managing the data for Quality Indicator 1: Pressure injuries are:

- **Collecting, recording and summarising the raw QI data** from the assessment of each resident.
  
  This involves counting the number of each classification of pressure injuries for each resident and obtaining a total for each classification of pressure injuries and the related comments for your residential facility. Further information, examples and sample formats for collecting, recording and summarising the QI data are available at Appendix 4.

- **Submitting the raw QI data** to the National Aged Care Quality Indicator Program section of the My Aged Care Provider Portal (the Provider Portal).
  
  The information you require for submitting data to the Provider Portal is outlined in Chapter 7: How to submit Quality Indicator data and how to access reports.

More information and resources in relation to Quality Indicator 1: Pressure injuries can be found at Appendix 3.

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5. Quality Indicator 2: Use of physical restraint

5.1 Objective
To monitor the proportion of use of physical restraints and trends.

5.2 Why monitoring physical restraint is important
Restraint is any aversive practice, device or action that interferes with a resident’s ability to make a decision or which restricts their free movement.

Evidence suggests that the use of physical restraint in residential aged care is between 12 and 49 per cent (Alzheimer’s Australia 2014).

This is despite research that indicates physical restraint can cause negative physical and psychological outcomes (Engberg, Castle & McCaffrey 2008).

There are a number of adverse clinical events associated with physical restraint, including:
- death
- mental health decline, with decreased cognitive function and depression
- increased social isolation
- pressure injury development
- incontinence
- falls
- confusion
- aggression
- decreased mobility
- infection
- under-nutrition
- decreased muscle strength
- pain.

5.3 Key facts
- Physical restraint is an act of removing an individual’s rights to freedom and autonomy.
- A family member and legal representatives do not have the legal right to request that a resident be restrained.
- Decisions to use or not use physical restraints may raise ethical questions and dilemmas for care workers.
- The evidence indicates restraint does not prevent falls or fall-related injuries and is likely to exacerbate behaviours.
- A restraint free environment is the recommended standard of care.
5.4 How to collect and report this indicator

5.4.1 Measures and data collection

- Every resident should be assessed for physical restraint.
- There are two measures to be collected for physical restraint during each of the assessments.
- Collect data by doing the assessments through observation of each resident.
- There are a total of nine observation assessments over the quarter. Identify three assessment days in the quarter. On each of these assessment days, conduct three assessments of all residents – one during the morning, one in the afternoon and one at night.
- Observation assessments should be unannounced to staff and residents.

5.4.2 Measure 1: Intent to restrain

- This measure is defined as the intentional restriction of a resident’s voluntary movement or behaviour by the use of a device, or removal of mobility aids, or physical force for behavioural purposes.
- This measure requires observation and recording any instance where any restraint equipment or action is in place to intentionally restrain a resident using devices or actions contained in the definitions A, B or C (described in section 5.5).

5.4.3 Counting rule

- Example 1: If at the time of the assessment it is observed that bedrails (definition A) are in use to intentionally restrict a resident from getting out of bed, then the count would be ‘1’. If the resident was also restrained with a safety vest (definition B) at the same time, then the count would be ‘2’.
- Example 2: If a resident is being intentionally restrained in a deep chair (definition A) and with a lap rug with ties (definition C), this should be counted as 2.
- Example 3: If a resident was intentionally locked in their room (definition C), then this action would be counted as ‘1’. If the resident was also sitting within the room with a locked table (definition B) in place then the count would be ‘2’.

5.4.4 Comments section on the data recording sheet

Include the following in the comments section on your data recording sheet for measure 1:

- Record the total number of actual residents who were being intentionally restrained at any time during the assessments.
- Record the number of restraints used that are specifically requested by the resident and/or their family or advocate.
5.4.5 Measure 2: Physical restraint devices

This measure is about counting **all devices** in use at the time of the assessments for any reason in accordance with definition B. These are to be counted whether they are being used to intentionally restrain a resident or not.

5.4.6 Counting rule

- **Example 1:** If at the time of an assessment it is observed that bedrails are in use without the intention to restrain (e.g. at resident request) this should be counted as ‘1’.
- **Example 2:** If during an assessment it is observed that bedrails are intentionally in use to restrict a resident from getting out of bed, this should be counted again for measure 2 as ‘1’, even though it has already been counted under measure 1.

5.4.7 Comments section on the data recording sheet

Include the following in the comments section on your data recording sheet for measure 2:

- Record the number of uses of restraint that were specifically requested by the resident and/or their family or advocate.

5.5 Definition of key data elements

5.5.1 Definition A: Intent to restrain

Physical restraint is defined as the ‘intentional restriction of a resident’s voluntary movement or behaviour by the use of a device, or removal of mobility aids, or physical force for behavioural purposes’ (Department of Health and Ageing 2012).

‘Physical restraint devices include but are not limited to lap belts, table-tops, posey restraints or similar products, bed rails and chairs that are difficult to get out of, such as beanbags, water chairs and deep chairs’ (Department of Health and Ageing 2012).

5.5.2 Definition B: Physical restraint devices

Devices commonly associated with physical restraint include:

- bedrails
- chairs with locked tables
- seatbelts other than those used during active transport
- safety vests
- shackles
- manacles.
5.5.3 Definition C: Other restraints
- Definitions A or B do not list all possible physical restraints. The assessment process should consider whether placement of furniture, use of concave mattresses, lap rugs with ties or any other devices are used with the intention to restrict free movement. If so, these should be included in measure 1.
- Actions such as intentionally locking residents in their rooms should also be included in measure 1.

5.5.4 Exclusions
Secure areas and perimeter alarms are not included for the purpose of this indicator.

5.5.5 Inclusions
Make sure you include respite residents in the observational assessments.

5.5.6 Quick tips for data accuracy
- Information for this indicator is collected through actual observation and not a documentation assessment.
- Ensure indicator information is collected consistently. For example, two people independently observing and interpreting the use of physical restraint must both report it in the same way.

5.6 Considerations for undertaking unannounced assessments
- Do not disclose the timing of the observational assessment to staff, except for the person conducting the observation.
- Assessments should be performed by staff who are not involved in direct care of residents on that day.
- The person conducting the assessment should directly observe all residents at the allocated time. The person should walk through the facility and record any uses of restraint.
- In larger organisations, observations can be made by managers as they perform routine visits, or by quality staff during the day and by supervisors at night.
- In some smaller facilities, the only staff present onsite at night are direct care staff. Telling a staff member to conduct an assessment related to restraint may result in altered practice and therefore influence the count. An alternative may be for managers to contact night staff at a certain time (previously undisclosed) and ask staff to conduct the assessment at that time. This approach may reduce the possibility of altered work practices.
- Staff who conduct the assessment should have a good understanding of the definition of restraint.
- If a resident is restrained by more than one type of restraint, count each restraint. This applies to measure 1 and measure 2.
- Ensure data collection is accurate so that you can more reliably set targets and compare your own internal performance and your performance against other residential facilities.

5.7 Important note
- Any use of physical restraint should be investigated at the time of the assessment.
• Check the appropriateness of any restraint authorisation documentation for individual residents, where it is in use.

• Restraint should only be used as a last resort, with regular processes in place for checking and reviewing ongoing need.

• In exceptional circumstances where restraint is being considered or used it is very important to remember the following:
  - Physical restraint is an act of removing a resident’s rights to freedom and autonomy.
  - Even if physical restraint is used as a temporary method of maintaining resident safety during a procedure, it must still be regarded as restraint.
  - The reason for using physical restraint must be thoroughly weighed against the negative consequences of restraint.

5.8 Frequently asked questions about physical restraint

Q. If a physical restraint that stops resident’s freedom of movement is being used to prevent a resident falling, or some other hazardous situation, should this be counted for this indicator?

   A. Yes. If the device or action restricts a resident’s freedom of movement it counts as restraint.

Q. If there are questions about a resident’s capacity for voluntary movement or behaviour, due to cognitive issues, should their physical restraint still be counted in this assessment?

   A. Yes.

Q. If an item that is normally classified as a ‘restraint’ is being used at the request of the resident or family/advocate, should this be counted as restraint in this assessment?

   A. Yes. If the item meets definition A – intent to restrain, it is to be counted in measure 1. If the item is listed in definition B – physical restraint device, it is to be counted in measure 2.

Q. Do all concave mattresses and water chairs count as restraint?

   A. Yes. If the use of concave mattresses and water chairs meets definition A – intent to restrain, and restrict a resident’s freedom of movement.

   No. If the concave mattresses and water chairs does not restrict a resident’s freedom of movement in any way.

   No. If the resident is unable to independently move themselves in any way.

   This also applies to other items such as recliner chairs, deep chairs, bean bags, etc.

Q. If seatbelts are being used while people are being showered in shower chairs, do these count as restraint?

   A. Yes. If the use of the seatbelt meets definition A to intentionally restrict a resident’s voluntary movement or behaviour, and the resident is not being actively transported, it is to be counted in measure 1.

   Yes. If the seatbelt is in use (and does not meet definition A – intent to restrain) and the resident is not being actively transported, it is to be counted in measure 2.

   No. If the seatbelt is in use while the resident is being actively transported by a staff member to the shower (or toilet, for example).
Q. Is moving a resident’s bed against a wall restraint?

A. Yes. If by putting the bed against the wall meets definition A – intent to restrain, and restricts a resident’s freedom of movement.

No. If by putting the bed against the wall it does not restrict a resident’s freedom of movement in any way.

No. If the resident is unable to independently move themselves in any way.

5.9 Quality Indicator 2: Use of physical restraint – processes for managing Quality Indicator (QI) data

As outlined in Chapter 3, Figure 1, the processes associated with managing the data for Quality Indicator 2: Use of physical restraint are:

- Collecting, recording and summarising the raw QI data from the assessment of each resident.
  
  This involves counting the number of restraints for Measure 1: Intent to restrain and Measure 2: Physical restraint devices for each resident, and obtaining a total for each measure and the related comments for your residential facility. Further information, examples and sample formats for collecting, recording and summarising the QI data are available at Appendix 6.

- Submitting the raw QI data to the National Aged Care Quality Indicator Program section of the My Aged Care Provider Portal (the Provider Portal).
  
  The information you require for submitting data to the Provider Portal is outlined in Chapter 7: How to submit Quality Indicator data and how to access reports.

More information and resources in relation to Quality Indicator 2: Use of physical restraint can be found at Appendix 5.
6. Quality Indicator 3: Unplanned weight loss

6.1 Objective
To monitor the proportion of residents with unplanned weight loss and trends.

6.2 Why monitoring unplanned weight loss is important
Between 13 and 31 per cent of residents in aged care experience unplanned weight loss. There are many adverse clinical events that can occur as a result of unplanned weight loss including:

- death
- increased risk of hip fractures
- pressure injury development
- poor wound healing
- malnutrition.

Unplanned weight loss occurs among older people for a number of reasons, including:

- dementia
- behaviours linked to dementia such as pacing, wandering, inability to recognise food, forgetting to eat, forgetting how to eat, inability to feed self, loss of communication skills and paranoia regarding food
- polypharmacy
- protein energy malnutrition
- aged-related changes, sometimes called the ‘anorexia of ageing’, for example loss of taste, smell, sight, changes to the digestive system, and swallowing difficulties
- depression
- chronic disease
- poor dentition such as poorly fitting dentures and dental prosthesis, missing and decayed teeth
- social isolation
- physical and organisational environment.
6.3 How to collect and report this indicator

6.3.1 Measures and data collection

- All residents, except for the exclusions that are listed below, should be assessed for unplanned weight loss.
- There are two measures to be collected by assessing the weight records of all residents.

Measure 1: Significant unplanned weight loss

- If over the three month period a resident shows unplanned weight loss equal to or greater than three kilograms, record this change. This result is determined by comparing weight at the last weigh this quarter with weight at the last weigh last quarter. Both these weights need to be available to provide this result.

Measure 2: Consecutive unplanned weight loss

- If a resident shows an unplanned weight loss of any amount every month over the three consecutive months of the quarter, record this. This can only be determined if the resident is weighed on all three occasions.

6.3.2 Comments section on the data recording sheet

Include the following in the comments section on your data recording sheet:

- Residents may choose not to participate in this assessment, so provide an explanation if residents are not included, that is if there is a difference between total residents and the number of residents weighed.
- Indicate if any residents were included in both measures; that is if they lost three kilograms or more and lost weight every month for three months.

6.3.3 Exclusions

- Residents who are absent, for example, in hospital.
- A resident receiving end-of-life palliative care.
- Exclude respite residents.

6.3.4 Quick tips for data accuracy

It is important for assessing unplanned weight loss to note the following:

- Regularly calibrate weighing devices.
- Weigh residents at around the same date and time as the previous month on the same weighing device.
- Weigh residents in clothing of a similar weight each time and deduct this from the total weight to arrive at a result.
- Ensure summing of weight loss from month to month is accurate.

If a resident has unplanned weight loss or gain, consider weighing the resident again the next day to check if this is just a normal daily fluctuation and to confirm accuracy.
6.3.5 Counting rules

- You do not need to weigh all residents on a single day. You can weigh a number of people on each day of the month. For example, if your facility has 40 residents and there are 20 weekdays in a month, you may decide to weigh two residents each day.
- Each resident, however, must be weighed at monthly intervals and as close as possible to the same day of each month.
- Only residents who are included in all three weighs for the quarter can be evaluated against this indicator.
- Do not weigh residents if this causes them pain or distress. Using alternative weighing equipment may address this issue.

6.3.6 Important note

- Any unplanned and unexpected weight loss should be investigated promptly and appropriate treatment commenced.
- If a resident 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.

6.4 Definition of key data elements

- Unplanned weight loss is beyond the control of the individual.
- Unplanned weight loss is weight loss where there is no written strategy and ongoing record relating to planned weight loss for the individual resident.
- Significant weight loss is defined as unplanned weight loss equal to or greater than three kilograms over a three month period.
- Consecutive weight loss is defined as unplanned weight loss of any amount every month for a three month period.

6.5 Quality Indicator 3: Unplanned weight loss – processes for managing Quality Indicator (QI) data

As outlined in Chapter 3, Figure 1, the processes associated with managing the data for Quality Indicator 3: Unplanned weight loss are:

- **Collecting, recording and summarising the raw QI data** from the assessment of each resident.
  
  This involves counting the number of residents for Measure 1: Significant unplanned weight loss and Measure 2: Consecutive unplanned weight loss, for each resident and obtaining a total for each measure and the related comments for your residential facility. Further information, examples and sample formats for collecting, recording and summarising the QI data are available at Appendix 8.

- **Submitting the raw QI data** to the National Aged Care Quality Indicator Program section of the My Aged Care Provider Portal (the Provider Portal).
  
  The information you require for submitting data to the Provider Portal is outlined in Chapter 7: How to submit Quality Indicator data and how to access reports.
More information and resources in relation to Quality Indicator 3: Unplanned weight loss can be found at Appendix 7.

7. How to submit Quality Indicator data and access Quality Indicator reports

7.1 Introduction
As part of the National Aged Care Quality Indicator Program (QI Program) you will be able to enter your raw Quality Indicator (QI) data through the My Aged Care Provider Portal (the Provider Portal). The raw QI data is entered every three months.

After you have entered the raw QI data the system will collate the QI data, calculate the QI rates, summarise the information and produce facility reports. You will be notified after the QI rates are calculated using the occupied bed days (OBD) data. You can then access the facility reports through the Provider Portal.

7.2 Cut off dates to submit the raw QI data
As indicated in Chapter 3, the cut-off date for QI data entry is the 21st day of the month after the end of each quarter. This is for:

1: Pressure injuries
2: Physical restraint
3: Unplanned weight loss

Therefore, based on the financial year calendar, the raw QI data must be submitted no later than:

- Quarter 1 (1 July to 30 September) – 21 October
- Quarter 2 (1 October to 31 December) – 21 January
- Quarter 3 (1 January to 31 March) – 21 April
- Quarter 4 (1 April to 30 June) – 21 July

7.3 What if QI data is not entered on time or is entered incorrectly?
You are able to contact the Australian Government Department of Health (the department) to enter your raw QI data after the cut-off date or to correct incorrectly entered QI data. The reports prepared for residential facilities that do not enter their QI data will have null values for that quarter.

7.4 How to become a user of the Provider Portal
A new user in the first instance should contact their facility’s My Aged Care Organisational Administrator who is able to create a new user account for staff through the Provider Portal.²

The department has guidance material on setting up new facilities on its website.

² Responsibility for ageing and aged care moved to the Department of Health from the Department of Social Services (DSS) on 30 September 2015.
### 7.5 What am I able to do based on my role?

<table>
<thead>
<tr>
<th>ROLE</th>
<th>DESCRIPTION OF ACCESS</th>
</tr>
</thead>
</table>
| Administrator   | • provide staff access to the Quality Indicator application  
                   • manage the roles within the Quality Indicator application, and  
                   • enter, save and submit Quality Indicator data and targets. |
| Team Leader     | If you are a team leader, you can enter and save Quality Indicator data and targets.  
                   
                   *Note: Once the report is saved as final, the Administrator can submit the data.* |
| Staff Member    | If you are a staff member, you can enter and save Quality Indicator data and targets.  
                   
                   *Note: Once the report is saved as final, the Administrator can submit the data.* |

### 7.6 How do I provide access to the Quality Indicator application?

Only the Administrator can add the Quality Indicator application for all staff members and team leaders.

To add the Quality Indicator Tile, the Administrator must:

1. login to the My Aged Care Provider Portal, and  
2. select ‘Staff administration’ from the home page.
3. On the ‘Staff administration’ page, click on the staff member you would like to access to the Quality Indicator application.

For information about how to add a staff member to your facility, please refer to my aged care provider portal user guide part one - administrator functions.

4. Click ‘Edit staff details’.
5. Click the check box participating for ‘Quality indicators’ at the bottom of the staff details screen.

6. The staff member can now log into the My Aged Care Provider Portal and they will find the new ‘Quality Indicators’ tile on their homepage.
7.7 How do I set the Quality Indicator Targets for a facility?

The Administrator can set targets, for a facility, for each of the Quality Indicators. The targets are not set by the department.

To enter the Quality Indicator Targets, follow the steps below.

1. From the landing page, click on the Quality Indicators tile.

2. Click ‘Select facility’ to find the facility you will be setting targets for.
3. Click on the facility you are setting the Quality Indicator Targets for and click ‘Select’.

4. Select ‘Continue’.
5. Enter your targets for each of the Quality Indicators.

Note: If you are setting QI Targets, you should base your facility targets on the facility’s Quality Indicator rates.

6. Once all the targets are entered click ‘Save Targets’.
7.8 Entering quarterly Quality Indicator data for a facility

Team leaders and staff members can enter and save data as final, once the Administrator has given them access to the Quality Indicator application. Remember only the Administrator can submit the quarterly QI data.

It is also good to note that you may choose to ‘Save as draft’ at any time and come back later to ‘Save as a final’, which submits the data to the Administrator. You can also choose to clear the data and restart or cancel the entire submission.

To enter the Quality Indicator data, follow the steps below.

1. From the landing page, click on the ‘Quality Indicators’ Tile.

2. Click ‘Select Facility’ to bring up the facilities you can submit QI data for.
3. Select the facility you would like to submit QI data for and click ‘Select’.

There are five stages you can have when entering QI data for a facility. They are:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description of stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Started</td>
<td>Facility data entry has not been opened or viewed this quarter.</td>
</tr>
<tr>
<td>Open</td>
<td>The facility data entry has been started but no data has been saved. This happens</td>
</tr>
<tr>
<td></td>
<td>when you ‘select’ the facility but cancel before saving data or using the ‘Clear’</td>
</tr>
<tr>
<td></td>
<td>button.</td>
</tr>
<tr>
<td>In Progress</td>
<td>The facility data has been saved as draft for this facility but not saved as a</td>
</tr>
<tr>
<td></td>
<td>‘Final’ or ‘Submitted’.</td>
</tr>
<tr>
<td>Final</td>
<td>The facility data is saved as final and it is ready for the Administrator to submit</td>
</tr>
<tr>
<td></td>
<td>for the quarter.</td>
</tr>
<tr>
<td>Submitted</td>
<td>The Administrator has submitted the facility’s data for the quarter.</td>
</tr>
</tbody>
</table>
4. Click ‘Continue’.

5. Select the Quality Indicators you are submitting data for. You must select either ‘Yes’ or ‘No’ for each of the Quality Indicators. Only select ‘Yes’ if you are entering data.
6. When you select ‘Yes’ click on the arrow beside the Quality Indicator you are completing and the fields you need to complete will drop down. Then you can fill in the fields for each of the Quality Indicators.

**Note:** If you enter a high number you may receive a warning message as indicated below. This message will not stop you from saving or submitting your data, it is only a warning that the number entered seems to be high and you should double check.
7. A green tick will appear once the all QI data is entered for the relevant Quality Indicator.

8. Complete the associated fields for the other Quality Indicators you are submitting data for.
9. This step is only for staff members or team leaders. Review the QI data entered to ensure it is correct, then click ‘Save as Final’. This sends a notification message to your Administrator letting them know the QI data is ready to be submitted. At this point, you may wish to give your Administrator a copy of the QI data so they can also check the data entry.

10. If you are the ‘Administrator’ you should review the QI data before submitting it for the quarter. Once ready, click ‘Submit’ to submit your facility’s QI data for the quarter.
11. A screen will come up with the conditions of submission and click ‘Yes’ or ‘No’.

**Note:** If you click ‘No’ you will be taken back to the data submission screen and the data will not be submitted.

12. Once you have pressed ‘Yes’, your QI data for the quarter will be submitted.

You can now select another facility to submit data for or select ‘Continue’ to view your submitted data. You can select another area of the My Aged Care Provider Portal at the top of the screen and exit the Quality Indicator application.
7.9 Accessing the Quality Indicator Reports

To access Quality Indicator Reports follow the steps below.

1. From the landing page, click on the ‘Reports’ tile.

2. Select the report you want to view or download.
3. You must fill in the three mandatory fields to request a report.

4. Click on the Facility field and choose the appropriate facility.
5. Click on the Quarter field and choose the appropriate quarter.

6. Click on the Output Type field and choose the format you would like the report to be produced in. That is, PDF (for printing), CSV and Excel (for extracting data), or HTML (for viewing in an internet browser).
7. Once all the mandatory fields are completed, click on the ‘Request report’.

8. The report will then be generated.
9. Once the report is generated, you can choose to open save, or cancel the report.

10. Click open or save to view the report.
11. All recently requested reports can be accessed from the Reports and forms page.
7.10 How to read your facility's Quality Indicator Reports

You can run three reports and a data extract for your facility through the My Aged Care Provider Portal Reports tab. The following pages show examples of the three reports. The data extract is just the data that was entered for your facility.

**QI002 - Facility Summary Quarterly Report**

![Image of Facility Summary Quarterly Report]

- **Quality Indicators** - Show the change between the quarter selected and the previous quarter and the target that was set by the facility for the quarter. This allows a facility to compare this quarter results against this quarter targets and last quarter results.
- **Year to Date Average** - The average result for each indicator since the beginning of the Financial Year.
- **National Averages** - Show the average result for the quarter and Financial Year to Date for all participating facilities.

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www.myagedcare.gov.au
**QI003 - Facility Detailed Quarterly Report**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Results for Quarter</th>
<th>YTD Averages</th>
<th>National Averages</th>
<th>National Reference Ranges</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>This Quarter</td>
<td>Previous Quarter</td>
<td>% Change</td>
<td>Target</td>
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<td>Stage 1 pressure injuries</td>
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<td>Stage 2 pressure injuries</td>
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<td>9.00</td>
<td>-72%</td>
<td>1.00</td>
</tr>
<tr>
<td>Suspected deep tissue injury</td>
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<td>7.00</td>
<td>-80%</td>
<td>1.00</td>
</tr>
</tbody>
</table>

**Comments**

XXXX

Comments will appear for each Quality Indicator where they have been entered for the quarter.

Results for quarter shows the change between the quarter selected, the previous quarter and the target set by the facility for the quarter.

The Year to Date Average is the average results for each indicator since the beginning of the Financial Year.

The National Averages shows the average result for the quarter and Financial Year to Date for all participating facilities.

The National Reference Ranges have not been set. The reference ranges will have an upper and lower limit for each of the quality indicators. These limits will be set through research and consultation with the Quality Indicators Reference Group.
QI005 - Quality Indicator Report

Each Quality Indicator will appear as a separate page.

Graphical display of the data entered by a facility for this quarter versus the last quarter.

Graphical display of the average data entered by a facility over the last four quarters versus the National Average for the same period.

Graphical display of the data entered by a facility over the last four quarters.
8. Using information from the Quality Indicators for quality improvement

8.1 Introduction

A main objective of using the information from the Quality Indicators (QIs) is to continuously improve the care provided to residents. You will decide on your response to the information from the QIs and the quarterly reports.

This section discusses how your aged care residential facility can use information obtained from the QIs to assess your performance and respond to the results within your facility for continuous quality improvement. This can include using information from all the processes involved in the National Aged Care Quality Indicator Program (QI Program). That is, during the assessments undertaken for each indicator; when the raw indicator data is collected, recorded and submitted to the Australian Government Department of Health (the department); and when you access reports generated by the My Aged Care Provider Portal (the Provider Portal). During these processes you can undertake your own analysis of your raw QI data to inform continuous quality improvement as well as using the analysis in your reports.

To streamline your approach it is useful to have a documented process to respond to the data. Figure 5 is an example of a process model that can be applied to responding to QI results. This figure is available on the website in printable format.

8.2 Questions to consider prior to responding to the QI data

Accurate, reliable and valid data and information is a crucial basis for appropriate analysis, interpretation and response. Therefore it is essential that the method used to collect data for each QI is consistent with the guidance in this resource manual.

The following questions may be useful prior to responding to data:

- Are staff undertaking the assessments and collecting the QI data for each indicator in the same way that is consistent with the guidance in this resource manual?
- What mechanisms are in place to check the accuracy of the data?
- What mechanisms are in place that ensure staff understand which issues identified at the assessment stage of collecting QI data require immediate follow up?
- How are staff supported to understand the importance of data accuracy and the QI Program?
8.3 Responding to information from the assessments and data collection process

The person assessing residents for the quarterly data collection may identify situations that require further investigation. For example:

Figure 5: Responding to Quality Indicator results
• Any pressure injuries should be investigated to ensure there is an appropriate care plan for the resident.
• Any use of physical restraint should be investigated at the time of the assessment.
• Check the appropriateness of any restraint authorisation documentation for individual residents, where it is in use.
• Restraint should only be used as a last resort, with regular processes in place for checking and reviewing ongoing need.
• Any unplanned and unexpected weight loss should be investigated promptly and appropriate treatment commenced.

Staff need to be trained and supported so that they understand and can identify the issues that require immediate follow up or further investigation during assessment and data collection.

8.4 Interpreting results, monitoring trends and responding to these

We may expect that the interpretation from analysis of QI results will give us a clear answer. This is not always the case and sometimes there are no right or wrong answers. We must always analyse and investigate the data to appropriately interpret what it means. It is important to remember during the process of interpretation, QIs are only one of the tools to use to reflect on current practice and inform future practice and continuous quality improvement. The information from the QIs will always need to be considered with other available information to contextualise and interpret the results.

Monitoring trends and changes over time is an important part of the QI Program. Your QI rates and reports can be used to monitor trends and changes over time. QI results will always fluctuate and minor fluctuations are normal. A significant change, or trends that are below expectations (for example below the targets set) may require further analysis and investigation to determine if they represent sub-optimal performance.

Further analysis and investigation to appropriately interpret the results from the QIs can include comprehensively examining how the data was collected and determine whether data collection was is in accordance with policy, procedures and accepted standards as described in this resource manual, as well as any unusual circumstances. It is also important to comprehensively examine factors in relation to the provision of care. For example, is the clinical care provided by your facility following contemporary guidelines and do your policies about clinical care align with these, and are there systemic or unique issues? The objective of this is to understand the situation and seek to improve care. It is important to examine the change calmly and carefully.

There are many issues that may contribute to a rate not aligning with expectations. The following questions may be useful when monitoring trends:

• Is there an issue with how the data was collected and reported?
When multiple staff are responsible for data collection, it is possible for each person to have a different understanding of the definition and the process for data collection. It is important that your facility develops a robust system for data collection. This includes mechanisms to check the data, and train and evaluate staff responsible for data collection. Collecting QI data in the same way is important for data accuracy, validity and reliability. It also promotes efficient and effective use of time and resources and allows meaningful interpretation and use of the QI data for service improvement.

- Has there been a change in the risk profile of your facility?

An example of how a risk profile can change is one new resident with complex needs may have a number of pressure injuries, which will result in an increase in the QI data for pressure injuries. Once the pressure injuries are treated for this particular resident, a significant reduction of pressure injuries may occur. If the QI rate returns to previous levels, the unfavourable result can be attributed to this uncommon event. However, if deterioration is evident in the next cycle, further investigation is required to find the cause.

- Has a random or unusual event been experienced in your facility?

An example of a random or unusual event is an external emergency such as a bushfire or flood. Such events may impact a QI rate. An internal event such as an outbreak of gastroenteritis may impact the unplanned weight loss rate.

- Is it an issue with care?

This may be due to ‘normal process variation’. That is, variations in how different staff deliver care can influence the QI outcome. In order to minimise this effect, focus on implementing and standardising the use of evidence based care practice wherever possible.

- Is it an issue with sub-optimal care?

If you determine the variations are due to sub-optimal care, investigate to establish where, when, how and why, and implement an improvement plan. Policies and procedures and staff education may also require updating.

8.5 Reporting performance and communicating results

The reports accessed by facilities each quarter allow facilities to communicate their results and improvement activities to internal and external stakeholders. Facilities are encouraged to report their QI data, along with other data pertaining to service quality and performance, to their boards, residents, the families of residents, and regular visitors such as general practitioners and contracted health professionals, as well as the broader community.

When communicating the QI results, provide an interpretation of the results and your ongoing plan of action for improving care. Make sure your communication is appropriate for the audience – your governance board will have different needs to residents and their families.

8.6 Quality Indicators and aged care accreditation
Your participation in the QI Program is voluntary, however it does have the potential to support your accreditation process by demonstrating your continuous quality improvement mechanisms.

Participating in the QI Program is a commitment to monitor, prioritise and review your systems of care to strategically improve service quality. Showing how your facility integrates the evidence based aged care QI Program with your wider quality improvement processes may enhance the evidence you choose to present to the Australian Aged Care Quality Agency (AACQA) assessors during any assessment contact or accreditation audit.

Areas you may choose to discuss with the AACQA include:

- how your performance has changed over time
- what strategic goals and targets you have set for the longer term and your plan to achieve these
- the effectiveness of your systems for collecting, reporting, analysing, interpreting and responding to QI data.

Interpreting QI data is complex and multifactorial and you need to be confident about your data systems and the triggers for response. It is important to approach any data variation carefully and not jump to an instant conclusion about what the data means.

Indicators alert you to a potential problem – they do not provide data for drawing instant conclusions about the quality of care.

The information from the QIs used in the QI Program cannot say whether the care is right or wrong, or whether it is good or bad. The information tells us if rates change or are different in other facilities. A less than optimal performance in a specific QI does not necessarily mean a facility has a poor quality system or substandard care practices. It may be due to data collection or unexpected one-off events.

Any actions taken as a consequence of information from the QI Program need to be considered carefully. The first step is to undertake a review to better understand potential factors that may contribute to a less than ideal result. Reacting without gathering this information may lead to an unnecessary change to an established process.

Using the QIs will help you communicate your safety and quality approach and systems for continuous improvement to AACQA assessors.

Additionally, the tips for improved QI data accuracy included in this resource manual provide a focus on screening residents’ progress notes and records. These same records are an important source of evidence used in assessment contacts and accreditation audits by AACQA when assessing resident care.

Progress notes contain information such as how changes to residents’ care are identified, managed, reported, reviewed and evaluated. Having a process for the regular screening of residents’ progress notes/records will help ensure care issues have been appropriately referred, followed up and managed according to accepted policy, procedures and practice within your facility.
By regularly and systematically screening resident records you are better able to respond to any unacceptable variations or unforeseen care continuity, communication or practice issues.

This means outcomes for residents will be better, and you may reduce the risks and element of surprise about issues you may not have otherwise been aware of during an assessment contact or accreditation audit.

Table 1 highlights the aged care accreditation standards outcomes that are potentially positively influenced by the effective use of QIs for 1: Pressure injuries, 2: Use of physical restraint, and 3: Unplanned weight loss.

*Table 1: Aged care accreditation standards and the Quality Indicators*

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Aged care accreditation standards: potential positive outcomes</th>
</tr>
</thead>
</table>
| Pressure injuries          | 2.1 Continuous improvement  
                              | 2.4 Clinical care  
                              | 2.5 Specialised nursing care needs  
                              | 2.8 Pain management  
                              | 2.9 Palliative care  
                              | 2.11 Skin care  
                              | 4.7 Infection control |
| Use of physical restraint  | 2.1 Continuous improvement  
                              | 2.13 Behavioural management  
                              | 2.14 Mobility and dexterity  
                              | 3.5 Independence  
                              | 3.6 Privacy and dignity  
                              | 4.4 Living environment |
| Unplanned weight loss      | 2.1 Continuous improvement  
                              | 2.4 Clinical care  
                              | 2.5 Specialised nursing care needs  
                              | 2.10 Nutrition and hydration  
                              | 2.15 Oral and dental care  
                              | 2.16 Sensory loss  
                              | 3.9 Choice and decision making  
                              | 4.8 Catering, cleaning and laundry facilities |

Information about using data from the QIs for quality improvement can be found at:
- Appendix 9 – Using Quality Indicator data and setting targets
- Appendix 10 – Quality Indicators, the quality improvement cycle and continuous quality improvement.
9. Support for residential facilities participating in the National Aged Care Quality Indicator Program

A range of resources are available so that you can participate in the National Aged Care Quality Indicator Program (QI Program) as easily as possible. Some of these are outlined below.

9.1 Preparation to participate

Preparation will support your participation in the QI Program and increase the likelihood of a successful introduction at your facility or facilities.

- Access the training and support materials available on the Australian Government Department of Health (the department) website. Training includes instructional videos on using the QI Program on the My Aged Care Provider Portal (the Provider Portal), along with reports, FAQs, this resource manual and a range of forms, information sheets, posters and printable formats.

- Conduct your internal planning and set up. Undertake planning within your residential facility to support the introduction of the QI Program. You may wish to consider the following approaches, noting that these are suggestions only, and your residential facility will have its own way of approaching planning for the introduction of the QI Program.

- Inform staff about the QI Program and the Quality Indicators (QIs) that will be used.

- Provide information to residents about your facility’s participation in the QI Program – see Appendix 11 for information for residents and families.

- Outline key dates that you will collect the data and note these on a schedule. An overview of the dates is provided at Chapter 3, Figure 1: Overview of the timeframes and processes for residential facilities to manage Quality Indicator data for the National Aged Care Quality Indicator Program. Also, Appendix 2 provides an example template for scheduling QI data collection.

- Allocate QI Program responsibilities to staff. This may include:
  - A key staff member to coordinate the QI Program in your residential facility – to ensure data is collected, submitted and the facility reports are accessed.
  - A backup contact to assist with processes and be available in the case of leave or illness.
  - Additional staff members who are informed of the QI Program and are willing to answer questions from residents and families.
  - A staff member, such as the Director of Nursing, who may need to discuss the QI Program with management or your residential facility board.

- Discuss the QI Program with residents and their family members or carers.
9.2 Ongoing support

The department would like to encourage providers to review support materials and talk to colleagues to resolve any questions in the first instance.

If this does not assist in resolving the concern, please contact the My Aged Care provider and assessor helpline on 1800 836 799. The helpline will be available between 8am to 8pm Monday to Friday and 10am to 2pm Saturday, local time across Australia. Please note that any clinical questions may require referral to clinical specialists.
PART B: Appendices - resources and additional information

Appendix 1 – Quality Indicators
Appendix 2 – Example template for scheduling Quality Indicator data collection
Appendix 3 – Quality Indicator 1: Pressure injuries
Appendix 4 – Example template for recording data for Quality Indicator 1: Pressure injuries
Appendix 5 – Quality Indicator 2: Use of physical restraint
Appendix 6 – Example template for recording data for Quality Indicator 2: Use of physical restraint
Appendix 7 – Quality Indicator 3: Unplanned weight loss
Appendix 8 – Example template for recording data for Quality Indicator 3: Unplanned weight loss
Appendix 9 – Using Quality Indicator data and setting targets
Appendix 10 – Quality Indicators, the quality improvement cycle and continuous quality improvement
Appendix 11 – Information for stakeholders including residents and families
Appendix 1 - Quality Indicators

Quality Indicators (QIs) today

The information technology revolution in the last 25 years has radically changed the way we gather, analyse and share data about the provision of care in all human service settings.

Healthcare, aged care, disability care and childcare services are all now expected to collect and report on performance data, and implement improvement measures as a result.

These processes are called different things depending on their context. They include terms such as:

- quality indicators
- health outcome measures
- performance indicators
- clinical indicators
- quality of life indicators
- performance outcome measures
- quality report cards
- dashboard indicators.

Although the terms we use are different, the goal remains the same: measure, report and seek to improve performance. What is indisputable is that indicators are accepted as a way to support improvement and are here to stay.

The goal is to measure, report and seek to improve performance.

Did you know? EA Codman, an American surgeon, is credited as the pioneer of a QI approach with his ‘end of results’ idea. In the 1910s Codman wanted to know what happened to patients he had operated on and to explain why a poor outcome, such as death, may have occurred. Codman went on to advocate that each doctor and hospital gather this information and be judged by their performance.

Attributes of QIs

The attributes of a robust QI include:

- importance
- reliability and validity
- capacity to improve
- availability of data that is comparable and user friendly.

Importance is determined by significant mortality, morbidity or cost implications, and by the needs of residents.

Reliability and validity relate to the required technical attributes of measuring an event. For a QI to be reliable, we must be able to clearly and unambiguously define
what is being measured. For example, we should all have the same understanding of what constitutes ‘unplanned weight loss’, and be able to report it the same way in every facility. For a QI to be valid, we should have evidence that what we measure reflects the nature of the care received by the resident. It should also seek to reflect system-wide performance.

**Capacity to improve** means having measures that are sensitive enough to detect a real difference. Sometimes ‘significant difference’ arises in large population numbers as a product of statistical methods. Statistical significance does not equate to clinical significance.

**Data availability** means that data is low cost, easy to gather and timely.

**Comparable** QIs allow risk adjustment for inter-organisational comparison.

**User friendly** means that the results can be explained in plain language.

The combination of attributes selected and how they are weighted will influence the development and selection of the individual QI.

Indicators are either ‘rate-based’ or ‘sentinel events’. Rate-based indicators are the most common, and involve aggregation of many similar events to express a proportion or ratio. A sentinel event is a rare event of major significance that should be investigated when it occurs (for example, a fall leading to death from a head injury). These are typically the subject of a root cause analysis.

**Consider what happens next**

Once the suite of QIs has been decided, the next step is to establish a Program to collect, analyse, report and respond to these measurements.

At this stage, facilities may encounter barriers to changing practices.

Staff may be uneasy that the National Aged Care Quality Indicator Program will be used to show them up and punish them. They may be confused about why they have to undertake the new Program, or worried that collecting data will get in the way of caring for residents.

Staff may also be concerned about whether the processes used to collect and analyse the data will provide a fair representation of their work, or that more resources will be needed to implement the Program.

Staff training, encouragement and support can reduce these concerns and be the defining success factors in any indicator program.

**Data integrity and validation**

**Importance of data integrity**

**Definition and collection**

Using reliable definitions and data sources for QIs is central to providing useful information. A reliable QI will report consistent results when different people collect data from the same source.

Reliability has multiple elements.
The indicator definition must be reproducible – it must be clear, unambiguous, explicit and applied consistently by different people in different places. Education, training and assessing data collectors’ understanding of the QI help to reduce subjective variation between staff. You should provide written information to clarify ambiguous or commonly experienced difficulties. Data collected should always be checked for completeness and accuracy.

Data needs to be checked for completeness and accuracy.

The data sources you use must be an accurate reflection of what happens in your residential facility, and they must consistently capture the elements required for each QI.

A robust QI Program will test the reliability of data. This requires planning and completing data audits to check the information collected.

Validation

There are three methods for assessing validity:

- content (face) validity
- construct validity (refers to the adequacy of the measure – i.e. does it measure what is intended?)
- criterion (gold standard) validity.

Content validity, also described as ‘face validity’, is the most common method in the absence of published research evidence. It establishes whether indicators are intelligible and make sense to the informed user.

Ideally, both construct and criterion methods would also be used to test the validity of each QI. Criterion validity involves comparison with a ‘gold standard’ – however, no such standard currently exists for QIs.

Additionally there is currently no established gold standard for aged care indicators.

Questions to consider include:

Is the QI associated with quality of care?

For example, is there a direct link between quality of care and what is being measured?

Does it make sense? Is it an important aspect of care for the resident?

Does the QI improve overall care delivered in the residential facility?

This is a much broader perspective that focuses on the organisation and system-wide practice.

Even if residents of a particular facility rarely experience the event being measured, the QI is still relevant because it can prompt a review to discover why the event does not occur, and how this can be maintained.

QIs can be used to test systems to determine how events could occur, and they play an important role in risk management.
Appendix 2 - Example template for scheduling Quality Indicator data collection

This example template can be used or adapted to help you plan your collection, recording and submission of Quality Indicator (QI) data.

| Facility name: |
| Schedule for QI data collection |
| Quarter 3 2015 – 2016, January 1 to 31 March 2016 |

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Advice</th>
<th>Date of collection</th>
<th>Responsibility</th>
</tr>
</thead>
</table>
| 1. Pressure injuries | Every resident will be assessed for pressure injuries once each quarter. The assessment can be conducted either by assessing every resident over a set period of up to 14 days, or by identifying an assessment date for each resident and completing the assessment on the same day for each quarter. | Assessment period: All residents over 14 days

---/---/2016

to

---/---/2016

OR

A date for each resident | Name: |

| 2. Use of physical restraint | Every resident will be assessed by observation for use of physical restraint. There are two measures to be collected for physical restraint during each assessment. Identify three assessment days in each quarter. On each of these days, conduct three observations of each resident, one during the morning, one in the afternoon and one at night. This is a total of nine observation assessments over the quarter. Observations should be unannounced. Do not disclose the timing of the observation to staff, except for the person conducting the observation. | Assessment 1 on

---/---/2016 | Assessment 1:
Staff member to do the morning observation (name):

---

Staff member to do the afternoon observation (name):

---

Staff member to do the night observation (name):

--- |

| Assessment 2 on

---/---/2016 | Assessment 2:
Staff member to do the morning observation (name):

---

Staff member to do the afternoon observation (name):

---

Staff member to do the night observation (name):

--- |
<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Advice</th>
<th>Date of collection</th>
<th>Responsibility</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Assessment 3 on</td>
<td>Assessment 3:</td>
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<td></td>
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<td><em><strong><strong>/</strong></strong></em>/2016</td>
<td>Staff member to do the</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>morning observation (name):</td>
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<td>Staff member to do the</td>
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<td>afternoon observation (name):</td>
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<td>Staff member to do the</td>
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<td>night observation (name):</td>
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<td>--------------------------</td>
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<tr>
<td>3. Unplanned</td>
<td>Every resident, except exclusions, will be</td>
<td>Weigh residents each month</td>
<td></td>
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<tr>
<td>weight loss</td>
<td>assessed for unplanned weight loss.</td>
<td>and record on a QI data</td>
<td></td>
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<tr>
<td></td>
<td>There are two measures to be collected by</td>
<td>collection sheet.</td>
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<tr>
<td></td>
<td>assessing the records of all participating</td>
<td>Assess for unplanned weight</td>
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<tr>
<td></td>
<td>residents’ weight each month of the quarter.</td>
<td>loss at the end of each month.</td>
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<tr>
<td></td>
<td>Regularly calibrate weighing devices.</td>
<td>Assessment day:</td>
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<tr>
<td></td>
<td>Weigh residents at around the same date and</td>
<td>Month 1</td>
<td></td>
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<td></td>
<td>time as the previous weigh on the same</td>
<td><em><strong><strong>/</strong></strong></em>/2016</td>
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<tr>
<td></td>
<td>weighing device. Weigh residents in</td>
<td>Month 2</td>
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<td>clothing of a similar weight each weigh in</td>
<td><em><strong><strong>/</strong></strong></em>/2016</td>
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<td></td>
<td>and deduct this from the total weight to</td>
<td>Month 3</td>
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<td></td>
<td>arrive at a result.</td>
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<tr>
<td>Data submission</td>
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<td>______<strong><strong>/</strong></strong>/</td>
<td>Name:</td>
</tr>
<tr>
<td>to the My Aged</td>
<td></td>
<td>2016</td>
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<tr>
<td>Care Provider</td>
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<tr>
<td>Portal (when/</td>
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<td>responsible team member)</td>
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<td><em><strong><strong>/</strong></strong></em>/2016</td>
<td>Name:</td>
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</table>
Appendix 3 - Quality Indicator 1: Pressure injuries

Evidence to support this Quality Indicator (QI)

Quality Indicator 1: Pressure injuries highlights pressure injuries as a major and prevalent health concern for older people.

There is substantial evidence and research that demonstrates the development of pressure injuries as a significant issue for older people living in residential aged care.

Defining pressure injuries

A pressure injury as defined by the Australian Wound Management Association (2014) as 'a localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, shear and/or friction, or a combination of these factors.'

Pressure injury classification systems provide a consistent method of assessing and documenting pressure injuries. However determining the severity and scale of the problem, and the degree of tissue involvement and exact causal determinants has been inconsistent, with varying data and terminology used around the world.

Australian representatives have been working with many countries in order to develop the international clinical practice guideline with an international classification system using the following six categories/stages (AWMA 2012; National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance 2014):

- Stage I pressure injury: non-blanchable erythema
- Stage II pressure injury: partial thickness skin loss
- Stage III pressure injury: full thickness skin loss
- Stage IV pressure injury: full thickness tissue loss
- Unstageable pressure injury: depth unknown
- Suspected deep tissue injury: depth unknown.

Pressure injuries in aged care

Older people are particularly vulnerable to developing pressure injuries.

Age-related changes to skin integrity, malnutrition, chronic disease, immobility, incontinence, impaired cognitive status and frailty are issues associated with advanced age and are all cited as risks for the development of pressure injuries (Jaul 2010; WOCNS 2010; NPUAP 2009; Holm et al. 2007; Santamaria et al. 2005; Bates-Jensen 2001).

The Victorian Department of Health’s Pressure ulcer point prevalence survey (PUPPS 3) conducted in 2006 demonstrated that out of 1,222 patients identified as having pressure injuries, 988 (80.85 per cent) were 60 years of age or older.

The incidence of pressure injuries in Australian nursing homes ranges between 26–42 per cent (Santamaria et al. 2009). Bates-Jensen (2001) reports an incidence of 24 per cent among nursing home residents (USA).
Adverse clinical events and pressure ulcers

The most significant adverse clinical event associated with pressure injuries is an increased risk of mortality.

The Victorian Quality Council (VQC) points out in its 2004 report *Pressure ulcers: a cause for concern* that from 2001–2003, 923 deaths occurred as a direct or indirect result of a pressure injury.

Authors such as Jaul (2010), Takahashi (2008), Capon et al. (2007), Santamaria et al. (2005), all concur that pressure injuries significantly increase an older person’s risk of mortality.

Common causes of death as a result of pressure injury development include osteomyelitis\(^3\) and septicaemia (Jaul 2010; Bates-Jensen, 2001). Osteomyelitis is an infection of the bone and may be acute or chronic (Skinner 2006).

Wound infection is also an adverse clinical event associated with pressure injury. Infection can cause wound deterioration and stop the pressure injury from healing (Whitney et al. 2006), which may in turn reduce mobility and physical function, and increase the risk of morbidity.

It may also increase the risk of developing cellulitis (Moore and Cowman 2007). The risk of infection increases if necrotic tissue is present in the pressure injury. Necrotic tissue forms an environment that promotes bacterial growth (Bluestein and Javaheri 2008; Bates-Jensen and MacLean, 2007 and Macklebust and Sieggreen 2001). Infection most commonly occurs in stage 3 and 4 pressure injuries as they are open wounds and necrotic tissue may be present (Moore and Cowman 2007).

Pain is also cited as an adverse clinical event associated with pressure injury development (Jaul 2010; Bates-Jensen and MacLean 2007).

Causes of pressure injuries

There are a number of risk factors that contribute to the development of pressure injuries.

Friction and shearing are two common terms often used to describe how pressure injuries occur. Friction refers to two surfaces moving across each other, the result being the formation of a wound. This commonly occurs when a person is pulled across bed linen. Moisture also increases friction.

Shearing occurs when two surfaces move parallel to each other, for example when a person is positioned upright in a bed they tend to slide downward and their skin and bed linen shear to cause a wound (Dealey 2005).

Significantly for residential aged care facilities, older age is frequently cited in the available evidence as a common risk for the development of pressure injuries. Jaul (2010) states that 70 per cent of pressure injuries occur in people who are aged 70 years or older.

\(^3\) A pressure ulcer can provide an inlet for bacteria to enter the body and cause osteomyelitis.
Aside from the incidence of comorbidities and chronic diseases associated with older age that may contribute to pressure injury development, there are specific age-related changes to skin which also increase the risk of occurrence (Jaul 2010; Dealey 2005; and Macklebust and Sieggreen 2001).

These changes include:

- loss of skin elasticity
- loss of collagen
- thinning of subcutaneous tissue
- reduced muscle mass
- reduced perfusion and oxygenation of tissue
- increased fragility and dryness.

There are a number of other reasons why pressure injuries occur, all of which are relevant to residential aged care. These reasons are summarised in Table 2: Factors contributing to pressure injury development and residential aged care.
Table 2: Factors contributing to pressure injury development and residential aged care

<table>
<thead>
<tr>
<th>Issue</th>
<th>Relevance to pressure injury development and residential aged care</th>
</tr>
</thead>
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| Nutrition                                | Poor nutrition or malnutrition can reduce skin elasticity and lead to anaemia, which in turn reduces the flow of blood and oxygen to tissues. This can lead to the development of pressure injuries.  
Malnutrition also reduces muscle and fat that normally protect or ‘pad’ bony prominences. The reduced protection and increased exposure of bony prominences can lead to a greater risk of developing pressure injuries.  
In addition, residents with a pressure injury who do not have adequate nutritional intake will have delayed wound healing. Nutrients supplied may only maintain current health and not be sufficient to build new tissue, and the pressure injury may worsen. |
| Mobility                                 | Residents with reduced mobility, and who are bed- or chair-bound, have an increased risk of pressure injury development.  
They have greater exposure to friction and shearing forces, as well as direct pressure against skin surfaces.  
In addition, residents with reduced mobility may not be able to reposition themselves. Reduced mobility is cited in the evidence as the greatest risk for pressure injury development. |
| Comorbidities and chronic disease        | The presence of chronic disease and comorbidities may increase residents’ need for bed rest and can reduce mobility.  
Physiologically (depending on the type of disease or illness) blood flow and oxygenation to tissues may be reduced, muscle wastage may occur and the resident may also become malnourished. |
| Incontinence                             | Incontinence may be a risk factor for pressure injury development, particularly urinary incontinence which results in skin maceration leading to an increase in friction against the skin.  
Frequent washing of the skin due to urinary and faecal incontinence may reduce the skin’s natural oils and lead to dryness.  
Washing with soap removes the natural oils, so soap alternatives are often suggested. |
| Restraint                                | Residents who are restrained either physically or chemically have an increased risk of pressure injury development due to a decrease in mobility.                                                                                                                                 |
| Contracture                              | Pressure redistribution means spreading the weight (load) over the largest surface area.  
If a person becomes contracted, then the surface area is reduced, thus predisposing them to higher pressures.                                                                                                                                 |

Source: adapted from Elliot 2011; Amir et al. 2010; AIHW 2010; Jaul 2010; Dealey 2005; Barrois et al. 2008; Bluestein and Javaheri 2008; Holm et al. 2007; Whitney et al. 2006; AIHW 2003; Baumgarten et al. 2003; Wilkes et al. 1996.
Why are these issues significant?

- Approximately 40 per cent of aged care residents experience unplanned weight loss and malnourishment.
- Thirty-three per cent of aged care residents in Australia need a high level of assistance with activities of daily living such as mobility.
- Up to 65 per cent of aged care residents have two or more chronic diseases.
- Approximately 80 per cent of aged care residents in Australia experience incontinence.
- Twelve to 49 per cent of aged care residents experience physical restraint.

The evidence highlights that residents are at risk of pressure injuries. The following resources may assist residential facilities in their prevention and management of pressure injuries.

- resource list (below)
- Figure 6: Pressure injury risk management framework.

Resource list

A range of resources are available to assist residential facilities identify and manage pressure injuries. There are also wound management courses available for staff.

- [Australian Wound Management Association website](#), which includes *Prevention and treatment of pressure ulcers: clinical practice guidelines 2014*

- Department of Health, *Pressure ulcer basics online education program* (currently being updated to include stage 6 for pressure injuries)

- Joanna Briggs Institute, Best Practice information sheets ‘Prevention of pressure related damage’ and ‘Management of Pressure related tissue damage’ available with membership

- Tools and resources developed for the National Safety and Quality Service Standards: Standard 8 Preventing and Managing Pressure Injuries, including Queensland Health 2012

- West Australian Government Department of Health [wound education modules](#)
**Figure 6: Pressure injury risk management framework**

- **Risk identification**
  - What is the risk of developing a pressure injury?
  - 42% of people who live in aged care develop pressure ulcers.
  - 70% of pressure injuries develop in people aged 70 years and over.

- **Analysis**
  - Associated factors
    - Malnutrition or poor nutrition
    - Friction and shearing forces
    - Immobility
    - Poor skin integrity
  - Identify if any of these factors are present.
  - Implement appropriate management and examine causative factors in order to manage the risk of pressure injury development.

- **Adverse events**
  - Potential impacts
    - Death
    - Infection
    - Cellulitis
    - Reduced physical function
    - Pain
  - Factors associated with pressure injury development are managed in order to reduce pressure injury development and decrease adverse events.

- **Risk control**
  - Monitoring
    - Quality Indicator
    - Process data and audit
    - Norton scale
    - Braden scale
    - Waterlow risk assessment
  - Indicator data and audit identifies risk potential and is also used to demonstrate improvements to managing risk.

**Treatment**

Resources are available to assist residential facilities identify and manage a pressure injury. Some of these are listed above.

Appendix 4 - Example template for recording data for Quality Indicator 1: Pressure injuries

Pressure injuries data collection sheet

This example of a collection sheet can be adapted for use when collecting Quality Indicator (QI) data from each resident each quarter for Quality Indicator 1: Pressure injuries.

| Facility name: |
| Quality Indicator 1. Pressure injuries |
| Quarter 3 2015 – 2016, January 1 to 31 March 2016 |

<table>
<thead>
<tr>
<th>Assessment date</th>
<th>Resident (all residents)</th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
<th>Stage 4</th>
<th>Unstageable</th>
<th>Suspected deep tissue injuries</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 3 2016</td>
<td>Mrs Example code 114</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td></td>
<td>This resident is new and the injury was present on admission.</td>
</tr>
<tr>
<td>February 3 2016</td>
<td>Mr Example code 115</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td>This resident is receiving end of life palliative care</td>
</tr>
<tr>
<td>February 4 2016</td>
<td>Ms Example code 116</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td></td>
<td>This resident is new and the injury was present on admission.</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>3</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
<td>3 x Stage 1; 1 x Stage 3 and 2 x Stage 4 present on admission. 1 x Stage 1 from a resident receiving end-of-life palliative care.</td>
</tr>
</tbody>
</table>
Pressure injuries data recording sheet
This example of a recording sheet can be adapted for use to summarise your QI data collected (table above) for Quality Indicator 1: Pressure injuries. This information is a total for the facility for each quarter, which you will submit to the Australian Government Department of Health (the department) through the My Aged Care Provider Portal (Provider Portal).

<table>
<thead>
<tr>
<th>Pressure injuries</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of facility</td>
<td></td>
</tr>
<tr>
<td>Reporting quarter end date</td>
<td>Quarter 3 2015 – 2016, January 1 to 31 March 2016</td>
</tr>
<tr>
<td>Assessment completed date</td>
<td></td>
</tr>
<tr>
<td>Total number of residents assessed</td>
<td>3</td>
</tr>
<tr>
<td>Total number of residents in the facility</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of pressure injuries</th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
<th>Stage 4</th>
<th>Unstageable</th>
<th>Suspected deep tissue injuries</th>
<th>Total injuries</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
</tbody>
</table>

**Comments**

- **Required** if applicable – note any pressure injuries reported above that have been present since admission. From the example above, ‘3 x Stage 1; 1 x Stage 3 and 2 x Stage 4 present on admission’. In subsequent quarters, include these injuries in the ordinary count, no comment needed.
- **Required** if applicable – note the number of pressure injuries reported above that developed while the resident was away from the facility, for example, while in hospital or on holiday. From the example above, ‘nil’.
- **Required** if applicable – note the number of pressure injuries reported above that relate to a resident receiving end-of-life palliative care. From the example above, ‘1 x Stage 1’.
- **Include** residents receiving respite care.
- **Optional** – any other relevant comments.

The department would like to encourage providers to review support materials and talk to colleagues to resolve any issues in the first instance.

If this does not assist in resolving the concern, please contact the My Aged Care provider and assessor helpline on 1800 836 799. The helpline will be available between 8am to 8pm Monday to Friday and 10am to 2pm Saturday, local time across Australia. Please note that any clinical questions may require referral to clinical specialists.
Appendix 5 - Quality Indicator 2: Use of physical restraint

Evidence to support this Quality Indicator (QI)

Quality Indicator 2: Use of physical restraint highlights the use of restraint as a major issue for older people.

There is substantial evidence and research that demonstrates the use of physical restraint as having significant impacts for older people living in residential aged care.

Defining physical restraint

The Department of Health and Ageing 2012 Decision-making tool: supporting a restraint-free environment in residential aged care defines physical restraint in the following way:

‘Restraint is any practice, device or action that interferes with a resident’s ability to make a decision or which restricts their free movement’ (p. 24).

This definition of physical restraint is also supported by authors such as the Australian and New Zealand Society for Geriatric Medicine (2012) and Timmins (2008).

The following devices and equipment are considered to be physical restraint when intentionally used to restrict resident movement:

- bedrails/cot sides
- shackles
- manacles
- over-bed tray-tables
- tray-tables that ‘lock’ into chairs
- deep chairs such as ‘princess chairs’, or other chairs that are difficult to get out of such as recliner chairs
- posey belts
- lap belts and seatbelts other than those in a motor vehicle
- safety vests
- concave mattresses.

The significance of physical restraint in residential aged care

The incidence of physical restraint in aged care across Australia is poorly documented. However, available evidence suggests an incidence of 15–30 per cent (Johnson et al. 2009).

Evidence suggests that the prevalence of physical restraint use in residential aged care is between 12 and 49 per cent (Alzheimer’s Australia 2014).

Rationale for the use of restraint is often embedded in the perception that it reduces risks to resident safety (and the safety of others) as a result of falls, wandering, aggression, agitation and unpredictable behaviour.
There is also evidence that suggests older people living in residential aged care are physically restrained due to inadequate staff supervision.

Research indicates that the use of physical restraint can cause negative physical and psychological outcomes (Engberg et al. 2008). There may also be an inaccurate perception that using physical restraint to minimise risks to the resident’s safety does not constitute restraint. Regardless of the rationale for its use, any method of physical restraint should always be regarded as such (Department of Health and Ageing 2012).

It is likely that the variations in the incidence of physical restraint cited above are due to organisations’ different understandings of what actually constitutes restraint. This is supported by Meyer et al. (2008) and Fogel et al. (2009).

Regardless of the incidence of physical restraint, it is a significant issue in aged care because it is an infringement of the individual’s right to freedom and dignity (Gelkopf et al. 2009; Meyer et al. 2008; Royal College of Nursing 2008; Timmins 2008). This does not align with the objectives of the Commonwealth Charter of care recipients’ rights and responsibilities: residential care (Aged Care Act 1997 (Cwlth)).

Evidence also shows restraint may actually cause or exacerbate the adverse outcomes its use was attempting to address (Engberg et al. 2008). For example, physical restraint used to restrict unsafe movement of a resident who has delirium and is aggressive exacerbates their delirium and aggression (Australian and New Zealand Society for Geriatric Medicine 2012).

This example highlights the importance of understanding:
- what physical restraint is
- its appropriateness in residential aged care
- the negative outcomes associated with it.

**Adverse clinical events and the use of physical restraint**

Decisions to use or not use physical restraint may raise ethical questions and dilemmas for care workers. These challenges can be difficult and may not be easily resolved.

When deciding whether or not to use physical restraint, it may be difficult to avoid harm, as injury can be caused by either course of action.

Healthcare workers have an obligation to all those in their care, and if enabling one person’s freedom results in harm to others, then decision makers need to justify their decision based on the consequence of applying or not applying restraint (Royal College of Nursing 2008).

There is substantial evidence that shows the negative consequences associated with physical restraint and the older person. The evidence does not support the view that the use of physical restraint maintains safety and reduces the incidence of adverse clinical events such as falls.

However, the literature acknowledges that in some situations the use of physical restraint may be the last option available to manage a specific issue.
The psychological and physical adverse outcomes for residents caused by physical restraint can be serious. Research indicates that physical restraint clearly impacts on a resident’s mental health, including their emotional wellness and social engagement.

Castle (2006) demonstrates that residents who are restrained are more likely to become more impaired with respect to cognitive performance, depression and social engagement. They conclude that if facilities reduce the use of physical restraint, the prevalence of residents’ mental health problems is also likely to decline.

Other adverse events associated with physical restraint and the older person examined by several studies include damage to the individual’s dignity and autonomy as a result of being physically restrained.

The Australian and New Zealand Society for Geriatric Medicine (2012) cites emotional desolation, withdrawal, fear and anger as consequences of physical restraint.

Gastmans and Milisen (2005) add that an older person who is physically restrained may experience loss of dignity, social isolation, loss of self-respect and identity, and feelings of shame. These points are also supported by authors such as Timmins (2008) and Stubbs et al. (2009).

Mortality associated with or as a cause of physical restraint is cited frequently in available evidence (Australian and New Zealand Society for Geriatric Medicine 2012; Agens 2010; Lane and Harrington 2011; McCabe et al. 2011).

Gastmans and Milisen (2005) state that physical restraint is associated with an increased risk of mortality related either directly to the restraint device or associated with the restraint device. For example a resident may be restrained to reduce the risk of falling, but may in fact experience a fall as a result of being restrained, which then results in a head injury and ultimately death.

There are a number of other adverse clinical events aside from mortality associated with restraint cited in the available evidence, these are presented in Figure 7.


Why physical restraint occurs

There are many reasons why physical restraint is used in the aged care environment. However, there is no evidence that demonstrates physical restraint is of any benefit to aged care residents.

Available evidence does suggest there may be situations where physical restraint is sometimes required because all other options used to manage resident safety have failed.

The general consensus of the literature evaluated concludes there are six common reasons why physical restraint is rationalised for use among older people (Agens 2010; Australian and New Zealand Society for Geriatric Medicine 2012; Evans et al. 2003; Gelkopf et al. 2009; Huang et al. 2009; Knox 2007; Lane and Harrington 2011; McCabe et al., 2011; Meyer et al., 2008; Pellfolk et al. 2010; Saarnio and Isola 2009; Timmins, 2008).

These are:

- prevention of falls
- management of aggressive/inappropriate behaviour
- prevention of injury to the confused resident
- prevention of wandering
- reducing interference with ‘treatments’ and medical devices
- risk reduction during periods of low/inadequate staff supervision.
When measured against the adverse outcomes of the use of restraint outlined above it is clear that these rationales are contradictory. In addition, the Australian and New Zealand Society for Geriatric Medicine (2012) clearly states the use of physical restraint should never be used to compensate for inadequate staffing numbers.

Wang and Moyle (2005) also point out physical restraint is often perceived as a preventive strategy to reduce risks to residents. This issue is also supported by authors such as Johnson et al. (2009) and the Victorian Institute of Forensic Medicine (2006).

The use of physical restraint has also been linked to nursing and care worker knowledge, education and understanding of what constitutes restraint and the appropriateness of its application in the aged care setting. This is a skill set that has been demonstrated as inadequate in international studies (Huang et al. 2009).

This issue is highlighted by Johnson et al. (2009), who examine a restraint minimisation Programme in an Australian residential aged care facility. Nursing staff consistently demonstrated a belief that the benefits of physical restraint far outweighed the negatives associated with it.

Saarnio and Isola (2009) state that nursing staff may not be fully aware of alternative options, making it difficult for them to make an informed decision about its use. This is a significant issue considering nursing staff in residential aged care facilities are often the key decision makers regarding the use of physical restraint (Gelkopf et al. 2009; Huang et al. 2009).

Another issue is the request for the use of physical restraint by the resident or resident’s family. The previous Australian Government Department of Health and Ageing (2012) made a clear statement about requests for restraint by family members:

A family member or legal representative does not have the legal power to require that a resident be restrained. This is a clinical decision that must be made by appropriately qualified people.

The reasons for the decision to restrain and the process by which the decision was reached should be documented, as those making the decision are legally accountable for the decisions and consequences.

Source: Decision-making tool: supporting a restraint free environment in residential aged care, p. 22.

Several studies discuss resident perceptions of being physically restrained at their own request. Residents request the use of restraint because they believe it makes them feel ‘safe’ (Gastmans and Milisen 2005), it can stop them from falling (Gallinagh et al. 2001), and they trust that nursing and care staff are making the right decision to restrain them (National Ageing Research Institute 2005).

Physical restraint is often used to manage behavioural and psychological symptoms of dementia and prevent falls.

However the evidence indicates restraint does not prevent falls or fall-related injuries (Qureshi 2009) and, indeed, is likely to exacerbate behaviours.

A restraint-free care environment is the recommended standard of care (Rathnayake 2012).
The evidence highlights that restraint places residents at risk of adverse events. The following resources may assist residential facilities in their prevention and management of physical restraint.

- resource list (below)
- Figure 8: Physical restraint risk management framework

**Resource list**

A range of resources and information is available to support residential aged care facilities to achieve a restraint free environment.


NSW Department of Health 2006, *Guidelines for working with people with challenging behaviours in residential aged care facilities - using appropriate interventions and minimising restraint*, State Government of New South Wales, North Sydney
Figure 8: Physical restraint risk management framework

<table>
<thead>
<tr>
<th>Physical restraint</th>
<th>Risk management framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk identification</td>
<td></td>
</tr>
<tr>
<td><strong>What is the risk</strong></td>
<td></td>
</tr>
<tr>
<td>of using physical</td>
<td></td>
</tr>
<tr>
<td>restraint?</td>
<td></td>
</tr>
<tr>
<td>Associated factors</td>
<td></td>
</tr>
<tr>
<td>Falls prevention</td>
<td></td>
</tr>
<tr>
<td>Inappropriate</td>
<td></td>
</tr>
<tr>
<td>behaviour management</td>
<td></td>
</tr>
<tr>
<td>Prevention of injury</td>
<td></td>
</tr>
<tr>
<td>to self and others</td>
<td></td>
</tr>
<tr>
<td>Prevention of</td>
<td></td>
</tr>
<tr>
<td>wandering</td>
<td></td>
</tr>
<tr>
<td>Reduction of</td>
<td></td>
</tr>
<tr>
<td>interference with</td>
<td></td>
</tr>
<tr>
<td>treatments</td>
<td></td>
</tr>
<tr>
<td>Inadequate staffing</td>
<td></td>
</tr>
<tr>
<td>Potential impacts</td>
<td></td>
</tr>
<tr>
<td>Death</td>
<td></td>
</tr>
<tr>
<td>Pressure injury</td>
<td></td>
</tr>
<tr>
<td>Incontinence</td>
<td></td>
</tr>
<tr>
<td>Falls</td>
<td></td>
</tr>
<tr>
<td>Aggression</td>
<td></td>
</tr>
<tr>
<td>Decrease mobility</td>
<td></td>
</tr>
<tr>
<td>Infection</td>
<td></td>
</tr>
<tr>
<td>Under nutrition</td>
<td></td>
</tr>
<tr>
<td>Decrease muscle</td>
<td></td>
</tr>
<tr>
<td>strength</td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td></td>
</tr>
<tr>
<td>Monitoring</td>
<td></td>
</tr>
<tr>
<td>Quality indicator</td>
<td></td>
</tr>
<tr>
<td>process data and</td>
<td></td>
</tr>
<tr>
<td>audit</td>
<td></td>
</tr>
<tr>
<td>Evidence and</td>
<td></td>
</tr>
<tr>
<td>guidelines, for</td>
<td></td>
</tr>
<tr>
<td>example: Physical</td>
<td></td>
</tr>
<tr>
<td>restraint –</td>
<td></td>
</tr>
<tr>
<td>standardised care</td>
<td></td>
</tr>
<tr>
<td>process</td>
<td></td>
</tr>
</tbody>
</table>

Appendix 6 - Example template for recording data for Quality Indicator 2: Use of physical restraint

Physical restraint collection sheet

This example of a collection sheet can be adapted for use when collecting Quality Indicator (QI) data from each resident each quarter for Quality Indicator 2: Use of physical restraint.

<table>
<thead>
<tr>
<th>Facility name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Indicator 2: Use of physical restraint</td>
</tr>
<tr>
<td>Quarter 3 2015 – 2016, January 1 to 31 March 2016</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assessment 1: Date <strong>/</strong>/__</th>
<th>Observation (morning)</th>
<th>Observation (afternoon)</th>
<th>Observation (night)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure 1: Intent to restrain</td>
<td>total number of restraints</td>
<td></td>
<td></td>
<td>Box 1</td>
</tr>
<tr>
<td>Measure 2: Physical restraint devices</td>
<td>total number of restraints</td>
<td></td>
<td></td>
<td>Box 2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assessment 2: Date <strong>/</strong>/__</th>
<th>Observation (morning)</th>
<th>Observation (afternoon)</th>
<th>Observation (night)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure 1: Intent to restrain</td>
<td>total number of restraints</td>
<td></td>
<td></td>
<td>Box 3</td>
</tr>
<tr>
<td>Measure 2: Physical restraint devices</td>
<td>total number of restraints</td>
<td></td>
<td></td>
<td>Box 4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assessment 3: Date <strong>/</strong>/__</th>
<th>Observation (morning)</th>
<th>Observation (afternoon)</th>
<th>Observation (night)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure 1: Intent to restrain</td>
<td>total number of restraints</td>
<td></td>
<td></td>
<td>Box 5</td>
</tr>
<tr>
<td>Measure 2: Physical restraint devices</td>
<td>total number of restraints</td>
<td></td>
<td></td>
<td>Box 6</td>
</tr>
</tbody>
</table>
Physical restraint data recording sheet

This example of a recording sheet can be adapted for use to summarise your QI data collected (table above) for Quality Indicator 2: Use of physical restraint. This information is a total for the facility for each quarter which you will submit to the Australian Government Department of Health (the department) through the My Aged Care Provider Portal (Provider Portal).

<table>
<thead>
<tr>
<th>Use of physical restraint</th>
<th>Name of facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting quarter and date</td>
<td>Quarter 3 2015 – 2016, January 1 to 31 March 2016</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assessment date 1:</th>
<th>Number of residents assessed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment date 2:</td>
<td>Number of residents assessed:</td>
</tr>
<tr>
<td>Assessment date 3:</td>
<td>Number of residents assessed:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure 1: Intent to restrain</th>
<th>Assessment Day 1</th>
<th>Assessment Day 2</th>
<th>Assessment Day 3</th>
<th>Total for all 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>From box 1</td>
<td>From box 3</td>
<td>From box 5</td>
<td>Box 1 + 3 + 5</td>
<td></td>
</tr>
<tr>
<td>Measure 2: Physical restraint devices</td>
<td>From box 2</td>
<td>From box 4</td>
<td>From box 6</td>
<td>Box 2 + 4 + 8</td>
</tr>
</tbody>
</table>

Comments

Measure 1: Intent to restrain.

✓ **Required** if applicable – indicate the total number of residents who were intentionally restrained during any of the audits.

✓ **Required** if applicable – record the number of uses of restraint in the total that were specifically requested by the resident and/or their family and/or advocate. This will be the total of the three assessments, which is Box 7 + 9 + 11 from the table below. For example, ‘12 restraint uses from the total were water chairs requested by family.’

Measure 2: Physical restraint devices.

✓ **Required** if applicable – record the number of uses of restraint in the total that were specifically requested by the resident and/or their family and/or advocate. This will be the total of the three assessments, which is Box 8 + 10 + 12 from the table below. For example, ‘three restraint uses from the total were bedrails requested by some residents for security.’

✓ **Optional** – any other relevant comments in relation to Measures 1 or 2.

The department would like to encourage providers to review support materials and talk to colleagues to resolve any issues in the first instance.

If this does not assist in resolving the concern, please contact the My Aged Care provider and assessor helpline on 1800 836 799. The helpline will be available between 8am to 8pm Monday to Friday and 10am to 2pm Saturday, local time across Australia. Please note that any clinical questions may require referral to clinical specialists.
**Additional information in relation to the comments section**

This example of a collection sheet can be adapted for use when collecting QI data from each resident for the comments section.

<table>
<thead>
<tr>
<th>Facility name:</th>
<th>Observation (morning)</th>
<th>Observation (afternoon)</th>
<th>Observation (night)</th>
<th>Total</th>
</tr>
</thead>
</table>

**Quarter 3 Indicator 2: Use of physical restraint**

**Quarter 3 2015 – 2016, January 1 to 31 March 2016**

<table>
<thead>
<tr>
<th>Assessment 1: Date <strong>/</strong>/__</th>
<th>Time</th>
<th>By</th>
</tr>
</thead>
</table>

**Measure 1: Intent to restrain** - total number of restraints requested by a resident and / or their family and / or advocate.

Box 7

<table>
<thead>
<tr>
<th>Assessment 2: Date <strong>/</strong>/__</th>
<th>Time</th>
<th>By</th>
</tr>
</thead>
</table>

**Measure 2: Physical restraint devices** - total number of restraints requested by a resident and / or their family and / or advocate.

Box 8

<table>
<thead>
<tr>
<th>Assessment 3: Date <strong>/</strong>/__</th>
<th>Time</th>
<th>By</th>
</tr>
</thead>
</table>

**Measure 1: Intent to restrain** - total number of restraints requested by a resident and / or their family and / or advocate.

Box 9

<table>
<thead>
<tr>
<th>Assessment 4: Date <strong>/</strong>/__</th>
<th>Time</th>
<th>By</th>
</tr>
</thead>
</table>

**Measure 2: Physical restraint devices** - total number of restraints requested by a resident and / or their family and / or advocate.

Box 10

<table>
<thead>
<tr>
<th>Assessment 5: Date <strong>/</strong>/__</th>
<th>Time</th>
<th>By</th>
</tr>
</thead>
</table>

**Measure 1: Intent to restrain** - total number of restraints requested by a resident and / or their family and / or advocate.

Box 11

<table>
<thead>
<tr>
<th>Assessment 6: Date <strong>/</strong>/__</th>
<th>Time</th>
<th>By</th>
</tr>
</thead>
</table>

**Measure 2: Physical restraint devices** - total number of restraints requested by a resident and / or their family and / or advocate.

Box 12
Appendix 7 - Quality Indicator 3: Unplanned weight loss

Evidence to support this Quality Indicator (QI)

Quality Indicator 3: Unplanned weight loss highlights unplanned weight loss as a major issue among older people.

There is substantial evidence and research that demonstrates unplanned weight loss is significant among older people living in residential aged care.

Defining unplanned weight loss

A review of evidence based literature reveals that unplanned weight loss is generally referred to as unintentional weight loss. However, for the purpose of this publication, the term unplanned weight loss will be used to ensure alignment with this QI.

Unplanned weight loss is generally defined as weight loss that occurs involuntarily over a period of time, that is, weight loss that occurs as a result of circumstances beyond the voluntary control of the individual (Alibhai, Greenwood and Payette 2005; Hartford Institute for Geriatric Nursing 2006; Miyamoto, Higashino, Mochizuki, Goda and Koyama 2011).

Unplanned weight loss is both a symptom and consequence of disease. It remains one of the best indications of nutritional risk in residential aged care (American Dietetic Association 2010; Hartford Institute for Geriatric Nursing 2006; Morley, Anker and Evans 2009).

Unplanned weight loss is generally a clinical symptom of another disease process or syndrome including:

- protein-energy malnutrition
- anorexia of ageing
- sarcopenia
- illness and/or disease severity
- polypharmacy – medication side effects and interactions.

There is a particularly close correlation between unplanned weight loss and protein-energy malnutrition. Prevalence of malnutrition in the residential aged care setting ranges from 40–70 per cent (Watterson et al. 2009).

Two key Australian studies have concurred that the prevalence of malnutrition in residential aged care is approximately 50 per cent (Banks et al. 2007; Gaskill et al. 2008). In addition to this, those most at risk are residents over the age of 90 and/or those with high-level care needs (Banks et al. 2007; Gaskill et al. 2008; Watterson et al. 2009).

Normal weight loss for the older person can be expected to be only 0.1–0.2 kg a year (Wallace and Schwartz 2002).

The Dietitians Association of Australia (Watterson et al. 2009) has identified that measuring weight loss over time can predict malnutrition.
However, there is some variation regarding the definition of clinically significant weight loss in relation to malnutrition.

The ICD-10AM criteria for the diagnosis of malnutrition is as follows:

- **Severe**: BMI less than 18.5 kg/m² or unintended weight loss of more than 10 per cent
- **Mild and moderate**: BMI less than 18.5 kg/m² or unintended weight loss of more than 5–9 per cent.

The National Institute for Health and Care Excellence (NICE) in the UK provides three options for defining malnutrition:

- BMI less than 18.5 kg/m²
- Unintentional weight loss of more than 10 per cent in the last three to six months
- BMI less than 20 kg/m² and unintentional weight loss of more than 5–9 per cent.

The minimum dataset used in the United States defines unintentional weight loss as a decrease of more than 5 lbs (2.3 kg) in one month, or more than 10 lbs (4.5 kg) in six months.

**Unplanned weight loss in aged care**

Unplanned weight loss is highlighted in the literature as a significant health issue among older people, particularly those living in aged care facilities. Statistics regarding its prevalence vary.

Study data from Alibhai et al. (2005), Ruscin et al. (2005) and Payette et al. (2000) report the range of unplanned weight loss in adults over the age of 65 as 13–27 per cent. Whereas an older study by Finch et al. (1998) has indicated that the prevalence is 31 per cent for those over the age of 65 in long term care.

Unplanned weight loss should not be dismissed as natural age-related change (McMinn et al. 2011). Many causes of weight loss can be addressed if detected early (Dyck and Schumacher 2011). Nurses and other members of the care team play an important role in screening residents at risk of malnutrition or where there is clinical concern, and ensuring they receive adequate nutritional care (Chen et al. 2007; Hickson 2006; Merrell 2012; Watterson et al. 2009).

In the United States, weight loss is a key indicator of care provision in the long-term care environment (Morley et al. 2004). The Centers for Medicare and Medicaid Services (CMS) define unplanned weight loss in terms of avoidable and unavoidable. The focus is on the care provider's standards of practice in the identification, implementation, monitoring and evaluation of weight loss issues.

Avoidable weight loss is identified when it is evident that the care provider has failed to maintain standards of practice in nutritional management. Unavoidable weight loss is established when it is clear that despite adherence to practice standards, the resident continues to lose weight.
Adverse clinical events and unplanned weight loss

There are a number of adverse events that may occur as a result of unplanned weight loss in the elderly. These issues have a significant effect on the quality of life of older people in aged care (American Dietetic Association 2010; Banks et al. 2010; Beattie et al. 2014; Courtney et al. 2009; Dyck and Schumacher 2011; Metalidis et al. 2008; Watterson et al. 2009).

However, it should be noted that for 10–36 per cent of older people, the aetiology of weight loss is unknown (Hartford Institute for Geriatric Nursing 2006).

Evidence suggests that unplanned weight loss among older people has a direct correlation with an increased risk of mortality (ADA 2010; Australian and New Zealand Society for Geriatric Medicine 2007; Beattie et al. 2014; Challa et al. 2007; Tamura et al. 2013) within one year (Thomas et al. 2013).

This point is also supported by the British Geriatrics Society (2011), who state: ‘a number of studies have now shown that the relative risk of death is consistently highest in those underweight than those overweight and in older people this may be even higher than those who are obese’ (p. 2).

This risk further increases when unplanned weight loss is classified as clinically significant.

Unplanned weight loss increases the rate of bone loss, particularly in the hip (McMinn et al. 2011; Raynaud-Simon 2009). Where weight loss is five per cent or more from baseline weight, it will double the risk of falls and hip fractures among older people (Australian and New Zealand Society for Geriatric Medicine 2007; Watterson et al. 2009). Evidence also links unplanned weight loss to the development of pressure injuries (ADA 2010; Australian and New Zealand Society for Geriatric Medicine 2007; Challa et al. 2007; Iizaka et al. 2010; Raynaud-Simon 2009).

Wound healing is also impaired by poor nutritional intake, especially a poor intake of protein (Challa et al. 2007; BAPEN 2012; Gaillard et al. 2008; Raynaud-Simon 2009). Inactivity or becoming bed bound can occur due to functional decline, loss of strength and mobility (BAPEN 2012; Challa et al. 2007). In turn this can increase the risk of pressure injury development and poor recovery from chest infection (BAPEN 2012; National Collaborating Centre for Acute Care UK 2006).

Causes of unplanned weight loss

There are a number of reasons why unplanned weight loss may occur in older people living in residential aged care.

Unplanned weight loss in the elderly is a highly complex and multifaceted health concern that can involve social, environmental, emotional, psychiatric and physiological issues (Crogan and Evans 2009; Hartford Institute for Geriatric Nursing 2006; Dyck and Schumacher 2011; Strajkovic et al. 2011; Van Lanke et al. 2012).

Pain, illness, chronic, malignant and neurological disease can all contribute to weight changes in the older person (ADA 2010; McMinn et al. 2011; SCIE 2009).
But it is the growing prevalence of dementia and its link to weight loss that raises concern. Several studies indicate that the presence of dementia is linked to unplanned weight loss.

The current evidence is described in the report on Nutrition and Dementia published by Alzheimer’s Disease International (Prince et al. 2014). Dementia certainly affects the areas of the brain responsible for the control of appetite and energy (Prince et al. 2014).

Weight loss can commence long before the symptoms of cognitive decline appear and increase as the disease progresses (Albanese et al. 2013; Kurrle et al. 2012; Miyamoto et al. 2011).

According to the Australian Institute of Health and Welfare (2012), 53 per cent of nursing home residents (nationally) have a diagnosis of dementia. A study by Irving (2003) found that residents with dementia exhibit a much lower body mass index compared with residents without dementia.

When considering the relationship between unplanned weight loss and dementia, take into account the behavioural and other characteristics of dementia that could result in unplanned weight loss. Authors such as Prince et al. (2014), Kurrle et al. (2012), Aselage et al. (2011), Chang and Roberts (2008), Miyamoto et al. (2011), Gaskill et al. (2008) and Smith and Greenwood (2008) have explored these issues.

They include factors such as:
- pacing and wandering resulting in untreated increased caloric intake needs
- inability to feed self
- no longer knowing how to eat (apraxia)
- decline in communication skills
- inability to recognise food as food (agnosia)
- paranoia and mistrust regarding food
- forgetting to eat.

Some of these behaviours are described as aversive. Gillette Guyonette et al. (2007) describe aversive feeding behaviours as:
- dyspraxia and agnosia – unable to use utensils properly or recognise food
- resistance – avoiding food, refusing to open mouth, spitting out the food, and aggression towards the person assisting them
- oropharyngeal dysphagia – problems with control with mouth, tongue and swallowing
- changed behaviours and food preferences – wandering, refusal to eat requested food, altered preferences for taste or texture of food.

Many studies discuss the presence of protein energy malnutrition (PEM) among residents in aged care. PEM is the loss of lean body mass and adipose tissue that occurs as a result of low consumption of energy and protein (Raynaud-Simon 2009;
Suominen et al. 2009; Australian and New Zealand Society for Geriatric Medicine 2007. Unplanned weight loss is a symptom of PEM (Miyamoto et al. 2011).

Another concept explored in the literature is physiological age-related changes. While weight loss and malnutrition are not an inevitable consequence of ageing, the physiological changes that occur in older adults can increase the risk of it occurring (Hickson 2006).

These changes include:
- decreased senses of taste and smell
- changes to dentition (i.e. loss/damage of teeth, poorly fitting dental prosthesis, poor oral health)
- early satiety (feeling fuller quicker)
- reduced appetite
- changes in the gastrointestinal tract that lead to poor nutrient absorption
- reduction in cellular capacity to store water
- increased frailty
- swallowing difficulties
- reduced eye sight.

These changes all contribute to unplanned weight loss (ADA 2010; Australian and New Zealand Society for Geriatric Medicine 2007; Benelam 2009; Dyck and Schumacher 2011; Gaskill et al. 2008; Tamura et al. 2013).

This process of age-related physiological change is sometimes called ‘anorexia of ageing’ (ADA 2010; Australian and New Zealand Society for Geriatric Medicine 2007; Raynaud-Simon 2009; Smith and Greenwood, 2008).

There is also a correlation between unplanned weight loss in the elderly and polypharmacy, medication side effects and interactions (ADA 2010; Beattie et al. 2014, Hartford Institute for Geriatric Nursing 2006; Strjkovic et al. 2011).

Polypharmacy is a significant health issue among older people. It can cause nausea, vomiting, diarrhoea, anorexia and dysgeusia (distortion of taste) (Alibhai et al. 2005; McMinn et al. 2011; SCIE 2009). These are all factors that can lead to unplanned weight loss. Research conducted by Agostini and colleagues (2004) demonstrated that the risk of weight loss among older people increased with the more medicines they consumed.

Limited research has been conducted regarding the relationship between the ‘eating environment’ in residential aged care and unplanned weight loss by authors such as Nijs et al. (2006).

A more recent study by Ullrich et al. (2014) identified that protected meal times and proactive nutritional support overseen by nurses are necessary components to the management of unplanned weight loss and malnutrition in residential facilities.
Staffing issues can also affect unplanned weight loss in residents, including:

- resourcing and failure to prioritise staff duties to provide adequate assistance at meal times (Chubb et al. 2006; Dyck and Schumacher 2011; 2006; SCIE 2009; Taumra et al. 2013; Ullrich et al. 2014)
- poor staff knowledge and/or training in nutritional care (Chubb et al. 2006; SCIE 2009)
- systems and practices that either fail to identify the nutritional needs of residents or fail to communicate these needs to staff (Chubb et al. 2006; SCIE 2009)
- inadequate support, particularly for residents who are unable to communicate their nutritional needs, choices and preferences verbally (Carrier et al. 2007; SCIE 2009; Ullrich et al. 2014).

Issues related to the quality of, and access to, food choices that meet residents’ cultural, religious and personal food preferences should be considered (Crogan and Evans 2009; Dyck and Schumacher 2011; SCIE 2009).

Authors such as Brush and Calkins (2008) and Smith and Greenwood (2008) discuss the value of adjusting the eating environment to improve eating among residents, especially those with dementia.

Adjustment strategies include:

- reduction of visual and auditory stimulation
- limiting courses of food to one at a time (to limit confusion over choice)
- use of appropriate lighting
- increasing visual contrast between table linen and crockery (for example, if both table linen and crockery are white, residents may not be able to distinguish the location of food).

Depression and other psychological factors can also cause unplanned weight loss (ADA 2010; Chen et al. 2007; Crogan and Evans 2009; Hartford Institute for Geriatric Nursing 2006; McMinn et al. 2011; SCIE 2009; Tamura et al. 2013). In fact, Dyck (2007), Dyck and Schumacher (2011) has indicated that the risk of weight loss in residents with depression is three times higher than those without depression.

Depression among older people in Australia is a growing concern (Dow et al. 2011). A recent systematic review of prevalence data relating to psychological issues in residential aged care facilities found that 4–82 per cent of older people have depression to some degree (Seitz et al. 2010). McMinn et al. (2011) state that older people with depression may experience unplanned weight loss due to loss of appetite and a reduced motivation to eat.

This leads to discussion about the nature of weight loss and functional decline. Age-related physiological changes also involve the loss of muscle mass and strength, a condition called sarcopenia (ADA 2010; Miller and Wolfe 2008; Morley et al. 2006). This can impair residents’ functional ability by 30–50 per cent, as well as compromise the person’s ability to eat independently (Paddon-Jones et al. 2008; Ullrich et al. 2014).
Functional decline associated with chronic disease can also lead to unplanned weight loss.

American Dietetic Association (2010) states that chronic disease may lead to prescribed or self-imposed dietary restrictions and food intake that limits food variety and the intake of nutrients. For example an individual with heart disease may limit or eliminate all fats and foods containing fats. Where possible, restrictive diets should be avoided (ADA 2010).

The practical physical limitations that occur as a result of chronic disease should also be considered. For example an individual with chronic obstructive pulmonary disease (COPD) may find it too difficult to prepare meals due to shortness of breath or may become short of breath while eating, and as result may only eat partial amounts of meals. Similarly a person with Parkinson’s disease may be unable to prepare meals due to reduced dexterity as a result of tremors, and may require partial or full assistance with eating, leading to similar outcomes to those individuals with COPD.

There are other broader issues that can contribute to unplanned weight loss among older people.

These issues can be best explained using the mnemonic MEALSONWHEELS (Morley et al. 1995). This mnemonic is presented in Table 3. It is used by a number of authors such as Australian and New Zealand Society for Geriatric Medicine (2007) and McMinn et al. (2011) to provide broad explanations of unplanned weight loss in older people.

*Table 3: Mnemonic MEALSONWHEELS*

<table>
<thead>
<tr>
<th>M</th>
<th>Medication effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>E</td>
<td>Emotion and depression</td>
</tr>
<tr>
<td>A</td>
<td>Alcoholism</td>
</tr>
<tr>
<td>L</td>
<td>Late-life paranoia</td>
</tr>
<tr>
<td>S</td>
<td>Swallowing disorders</td>
</tr>
<tr>
<td>O</td>
<td>Oral factors such as poor dentition</td>
</tr>
<tr>
<td>N</td>
<td>No money (to buy food)</td>
</tr>
<tr>
<td>W</td>
<td>Wandering and other dementia-related behaviours</td>
</tr>
<tr>
<td>H</td>
<td>Hyperthyroidism and hypothyroidism</td>
</tr>
<tr>
<td>E</td>
<td>Enteric problems (malabsorption)</td>
</tr>
<tr>
<td>E</td>
<td>Eating problems (inability to feed self)</td>
</tr>
<tr>
<td>L</td>
<td>Low salt, low cholesterol diet</td>
</tr>
<tr>
<td>S</td>
<td>Social problems such as isolation, difficulty accessing food</td>
</tr>
</tbody>
</table>

Source: Morley et al. 1995

The evidence highlights that residents are at risk of unplanned weight loss. The following resources may assist residential facilities in their prevention and management of unplanned weight loss.

- resource list (below)
• Figure 9: Unplanned weight loss risk management framework.
Resource list

A range of resources are available to assist residential aged care facilities to manage a resident’s nutrition and unplanned weight loss.

- Department of Health, Standardised care process: unplanned weight loss, State Government of Victoria, Melbourne
- Department of Health, Standardised care process: dehydration, State Government of Victoria, Melbourne
- Department of Health, Well for life: improving nutrition and physical activity for residents of aged care facilities, State Government of Victoria, Melbourne
Figure 9: Unplanned weight loss risk management framework

Unplanned weight loss
Risk management framework

Risk identification

What is the risk of unplanned weight loss?
- Dementia
- Polypharmacy
- Protein Energy Malnutrition
- Age-related changes
- Depression
- Chronic disease
- Poor dentition
- Social isolation

13 to 30% of aged care residents experience unplanned weight loss. There is a clear link between older people who experience unplanned weight loss and mortality.

Analysis

Identify if any of these factors are present, implement appropriate management and examine causative factors in order to manage the risk unplanned weight loss.

Associated factors

Potential impacts
- Death
- Increased risk of hip fracture
- Pressure injury development
- Poor wound healing
- Malnutrition

Adverse events

Manage factors associated with unplanned weight loss to reduce the risk of it occurring or worsening.

Risk control

Monitoring
- Nutrition risk assessment
- Evidence and guidelines, for example: Standardised care process for unplanned weight loss and dehydration http://www.health.vic.gov.au/agedcare/services/score
- Quality indicator process data and audit


Treatment

Resources are available to assist residential facilities with unplanned weight loss. Some of these are listed above.
## Appendix 8 - Example template for recording data for Quality Indicator 3: Unplanned weight loss

### Unplanned weight loss collection sheet

This example of a collection sheet can be adapted for use when collecting Quality Indicator (QI) data from each resident each quarter for Quality Indicator 3: Unplanned weight loss.

<table>
<thead>
<tr>
<th>Facility name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Indicator 3: Unplanned weight loss (please note that all weights are in kgs)</td>
</tr>
<tr>
<td>Quarter 3 2015 – 2016, January 1 to 31 March 2016</td>
</tr>
<tr>
<td>Assessment date:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident</td>
<td>Weight carried forward from previous month</td>
<td>Jan</td>
<td>+ Or -</td>
<td>Feb</td>
<td>+ Or -</td>
<td>Mar</td>
<td>+ Or -</td>
<td>Total + or - for Quarter</td>
<td>1* Lost 3 Kg or more this quarter Y or N</td>
<td>2# Lost every month Y or N</td>
<td>Comments</td>
</tr>
<tr>
<td>Mrs Example code 114</td>
<td>83.5</td>
<td>83.7</td>
<td>+0.2</td>
<td>82.8</td>
<td>-0.9</td>
<td>80.4</td>
<td>-2.4</td>
<td>-3.1</td>
<td>Y</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Mr Example code 115</td>
<td>76.3</td>
<td>76.0</td>
<td>-0.3</td>
<td>75.5</td>
<td>-0.5</td>
<td>75.3</td>
<td>-0.2</td>
<td>-1.0</td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Ms Example code 116</td>
<td>80.0</td>
<td>80.0</td>
<td>-</td>
<td>-</td>
<td>80.5</td>
<td>+0.5</td>
<td>+0.5</td>
<td>N</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total

<table>
<thead>
<tr>
<th>1</th>
<th>1</th>
</tr>
</thead>
</table>

* In hospital in February and weight could not be measured, therefore not included for either measure in the total
Unplanned weight loss data recording sheet
This example of a recording sheet can be adapted for use to summarise your QI data collected (table above) for Quality Indicator 3: Unplanned weight loss. This information is a total for the facility for each quarter which you will submit to the Australian Government Department of Health (the department) through the My Aged Care Provider Portal (Provider Portal).

<table>
<thead>
<tr>
<th>Unplanned weight loss</th>
<th>Name of facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting quarter end date</td>
<td>Quarter 3 2015 – 2016, January 1 to 31 March 2016</td>
</tr>
<tr>
<td>Assessment date</td>
<td></td>
</tr>
</tbody>
</table>

Measure 1: Significant unplanned weight loss. This is the number of residents who experienced over the three month period unplanned weight loss equal to or greater than three kilograms.

<table>
<thead>
<tr>
<th>Number of residents whose weight was monitored*</th>
<th>Number of residents who experienced significant unplanned weight loss</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>This is the total number of ‘Yes’ in column 10. For this example 1.</td>
</tr>
</tbody>
</table>

Measure 2: Consecutive unplanned weight loss. This is if a resident experiences unplanned weight loss of any amount every month over the three consecutive months of the quarter. This can only be determined if the resident is weighed on all three occasions.

<table>
<thead>
<tr>
<th>Number of residents whose weight was monitored*</th>
<th>Number of residents who experienced consecutive unplanned weight loss</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total number of ‘Yes’ in column 11. For this example 1.</td>
</tr>
</tbody>
</table>

*Note: If a resident is in hospital on any of the weigh dates they are excluded from both measures.

Comments

- **Required** if applicable – explain any difference between total residents and the number of residents whose weight was monitored. Such as residents who died, residents who were in hospital for one or more of the weighs and residents who choose not to participate in the monitoring. From the example above, ‘one resident was in hospital on the second weigh day’.
- **Required** if applicable – indicate the number of residents who were included in both measures; that is if they lost three kilograms or more over the three months and lost weight every month for the three months. From the example above, ‘nil’.
- **Optional** – any other comments.
Appendix 9 - Using Quality Indicator data and setting targets

Using Quality Indicator (QI) data – governance

The modern concept of responsibility in the provision of health and aged care services is described as clinical governance. This is defined as the system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving care, minimising risk and fostering an environment of excellence in care for residents.

In essence this means that everyone at all levels within an organisation is responsible for the standard of care, including staff, management, the executive and the board of directors.

A successful National Aged Care Quality Indicator Program (QI Program) requires everyone in an organisation to fulfil their roles and responsibilities. Each group will use and interpret information from QIs differently. The common goal for all is to provide excellent care and continually look for ways to further improve.

- **Board and executive**

  The role of the board and executive is to provide the governance, leadership and oversight for quality of care. This includes ensuring the adequacy of systems and resources to gather, report and respond to QI information, and to consider the merits of the different interventions required for improving care and the organisation as a whole.

- **Managers and quality personnel**

  The role of senior managers and quality personnel is to understand the principles and practical application of QIs and their limitations.

  Their role is to support the implementation and facilitate the interpretation of information relevant to service delivery. This may include active management and participation in the collection, reporting and responding to QIs.
They also implement specific interventions within the facility to improve care, such as explaining the facility’s QIs to staff. The challenge is personalising QI data so it is relevant and real. This requires translating the data in a way that will be meaningful. Having information about both the individual residents and all residents is essential. QIs that give an overview or a summary of how a facility operates are very helpful.

Accumulating summary information requires selecting the most important factors that occur in the majority of interactions at the point of care with residents. This often leads to an unfair criticism that the individual nuances of delivering and accepting care are lost. This is inherent in summarising data. There are also different methods for gathering this type of information.

What may not be visible are the individual one-on-one resident and point of care interactions that occur every minute of every day. This is why the use of QIs provides an opportunity for monitoring, maintaining and improving resident safety and quality systems.

The role of managers and quality personnel is to understand the principles and practical application of QIs.

- **Point of care staff**

  Staff experience, observe and participate in improvement initiatives that occur across the whole of their workplace.

  Their role is to ask questions, report gaps in care, suggest changes and implement initiatives to improve care for the benefit of the residents, themselves and the facility as a whole.

  What is visible to point of care staff is whether the facility provides the education, training, resources and support needed to make desired changes. Point of care staff will see this in terms of their immediate interactions with a limited number of residents and how it affects the work of their colleagues.

  What may not be visible to point of care staff are the organisation’s decision-making processes. This includes the information used to monitor and determine whether safety and quality programs are effective and appropriate. Point of care staff may also be unaware of how the multitude of initiatives for quality and safety compete for finite resources.

  The role of point of care staff is to ask questions, report gaps in care, suggest changes and implement initiatives to improve care.

- **Residents, families and visitors**

  Residents, families and visitors usually have a narrow but intense level of interaction with facilities and care staff.

  Not all QIs will be relevant to each individual resident.

  What is visible to residents and families is the staff response to any concerns or requests.

  What may not be visible are the systems of care for monitoring, maintaining and improving resident safety and quality.
Providing QI reports is an opportunity to showcase and explain the residential aged care facility’s systems of care.

| The role of residents, families and visitors is to ask questions about care. |

**Setting targets – introduction**

Setting a target rate for each indicator is a method that can assist you to interpret your QI rates and promote continuous quality improvement. The capacity to set target rates has been included in the My Aged Care Provider Portal (the Provider Portal) for your internal use and will not be published.

You will be able to set targets for each indicator with more confidence after you have become accustomed to the QI Program and when you are familiar with the QI rates and trends of your facility, as well as in comparison to the national rates. This may take several collection quarters to ensure you are confident in the stability and reliability of your data. Also as the QI Program develops nationally this will assist you to set target rates for each indicator.

For example in 12 months’ time you may set a target for a 10 per cent improvement on the previous years’ rates for each indicator. Once you set targets you can enter these in the *Complete QI result submission* form.

**What are targets and how can they be set?**

A target rate for each indicator provides a minimum level of accepted practice or steps toward that minimum level.

| Achieving targets are processes to get to a predetermined level. |

Setting targets can be challenging. It is like setting personal life goals, such as getting fit or saving money. We can be realistic and pragmatic; or optimistic and aspirational; or give ourselves an ultimatum or absolute goal.

| Targets can be realistic and pragmatic; or optimistic and aspirational. |

**Realistic targets**

Realistic targets make sense to us because they feel achievable and give us hope that we will attain the target and be successful. The downside is that we do not stretch ourselves. By staying in our comfort zone, we never know what is really possible.

**Aspirational targets**

Aspirational targets are set above what we think is possible. These targets may be met if we rethink how we do things and challenge current practice.

The downside of using an aspirational target is that practically-minded people may decide to give up altogether because they know the target is not achievable.

Aspirational targets challenge us to move beyond the ‘average’ and out of our comfort zone.

Optimal care requires setting aspirational targets that need planning and focused effort over time to achieve.
Absolutely targets

Absolute targets are the hardest of all to achieve.

The downside of absolute targets is these may seem unreachable and we will always fail.
**Applying different targets**

Let’s apply this to skin care and development of pressure injuries.

A realistic target might be having the same number of injuries this year as last year.

An aspirational target would be to halve the number of pressure injuries for next year.

An absolute target is to have no pressure injuries at all.

<table>
<thead>
<tr>
<th>When thinking about targets:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Which do you prefer?</td>
</tr>
<tr>
<td>What do the residents prefer?</td>
</tr>
<tr>
<td>How will staff behave with the different targets?</td>
</tr>
</tbody>
</table>

The real message being sent by using an absolute target is accepting the evidence that pressure injuries are preventable. The knowledge, skills, equipment and resources already exist in our world. Our challenge is putting this into practice.

<table>
<thead>
<tr>
<th>Important questions for facilities include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is our quality goal in a particular area?</td>
</tr>
<tr>
<td>Is it to be good, better or best?</td>
</tr>
<tr>
<td>What targets will we use to measure and monitor how we get there?</td>
</tr>
</tbody>
</table>

Determining whether the QI is associated with the quality of care is more difficult to establish.

To calculate the rate requires describing both the numerator and denominator. The numerator targets the event being tracked (such as number of pressure injuries), while the denominator is the total resident population who may be at risk (such as rate per 1,000 resident bed days).

Denominators can be made more specific by using subgroups based on demographic characteristics or the presence of underlying comorbid disease (for example, rate per 1,000 resident bed days according to different care classifications).

Note that if you use large denominators, changes in the numerator must be substantial for the QI rate to be noticeably altered – there is not much difference between one per 100,000 and two per 100,000 resident days. On the other hand, a small residential aged care facility may be unjustly blemished by the same numerator change if the denominator value is low, for example the difference between one per 100 and two per 100 resident days.
Appendix 10 - Quality Indicators, the quality improvement cycle and continuous quality improvement

Factors that influence quality of care

There are many factors that influence quality of care. These influences should be considered when reviewing your results from the National Aged Care Quality Indicator Program (QI Program). Table 4 includes some of these factors.

*Table 4: Factors that influence quality of care*

<table>
<thead>
<tr>
<th>Organisational capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>This relates to the effectiveness of structures and systems in place for supporting safe high-quality care through strategic planning and leadership, risk management, workforce training, professional development, competency and accountability, information management, consumer engagement and participation, team work, culture, and communication.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Internal systems of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>This relates to how care is planned and organised so that is safe, effective, appropriate, integrated and coordinated, informed by evidence and person-centred so that quality of life is experienced by every resident every day.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Incident and adverse event management and escalation</th>
</tr>
</thead>
<tbody>
<tr>
<td>This relates to the effectiveness of systems for recognising and responding to incidents and adverse events. Safety incidents are viewed as a learning tool to improve performance. This is achieved through incident analysis and investigation, effective incident management and escalation, identification of issues that lead to incidents or were an outcome of the incident; and providing feedback to those involved in the incident.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>External bodies</th>
</tr>
</thead>
<tbody>
<tr>
<td>The functions of organisations external to residential facilities can directly influence or have an effect on resident safety and care outcomes. Examples of external organisations include professional registration bodies (for example AHPRA), accreditation agencies, the State Coroner’s Office, and the Health Services Commissioner and Ombudsman.</td>
</tr>
</tbody>
</table>

Quality Indicators (QIs) and the quality improvement cycle

Residential facilities can implement the QI Program as an important component of their quality system that consists of a range of factors. As such the QI Program as an important component of a quality system can complement other safety, risk, accreditation, quality improvement, and innovation activities. The QI Program does not replace any of these. Together these support the provision of safe, high-quality care for residents.

Use of the indicators should be considered as only one mechanism within a suite of improvement activities required for an effective quality system to improve safety, reduce preventable harm and support every resident to experience quality of life every day.
The QI Program provides complementary information to that already gathered through different mechanisms such as complaints, incidents, adverse and sentinel events reporting, root cause analysis, surveys, audits (including structured clinical audits), process mapping, gap analysis, records review and adverse event screening, structured interviews, and administrative data.

Using a range of different techniques gives a fuller picture of what truly happens in your facility and provides an ability to cross check when one area is performing below expectations.

The QI Program can be incorporated into the Plan Do, Study, Act (PDSA) quality improvement cycle as effective drivers for change and improvement.

Figure 10 illustrates how the ongoing cycles of data collection and reporting processes for the QI Program can sit alongside an organisational risk management approach for managing resident risks. In this example, the continual monitoring, analysis and review of the data and reports for the QIs could directly inform the need for actions or interventions to minimise risks to residents.

Figure 10: Quality Indicators as part of the Plan, Do, Study, Act cycle
Appendix 11: Information for stakeholders including residents and families

Introduction

The information in this appendix contains four separate information sheets for different stakeholders that help to explain the National Aged Care Quality Indicator Program (QI Program). These are available to print out.

**General practitioners**
- For general practitioners who provide care to residents in residential facilities.
- Note this information is also useful for other visiting health professionals such as dentists, occupational therapists, physiotherapists, speech pathologists and dietitians.

**Clinical and care team**
- For managers and quality coordinators for residential facilities, registered nurses, enrolled nurses, personal carers, allied health professionals and lifestyle workers.

**Resident and family**
- For residents of residential facilities, their family and advocates.

**Board directors and executives**
- For board directors, chief executive officers and executive directors of residential facilities.

There are also information sheets for consumers on the My Aged Care website at www.myagedcare.gov.au.
Information for general practitioners

Across Australia every Commonwealth subsidised residential aged care facility (residential facility) is invited to participate in the National Aged Care Quality Indicator Program (QI Program).

The QI Program measures different aspects of care.

The specific indicators used in the QI Program for residential facilities are:

1: Pressure injuries
2: Use of physical restraint
3: Unplanned weight loss

These areas can all have serious and potentially catastrophic impacts on the physical, mental, emotional and spiritual health for residents. Monitoring and measuring performance in these areas is vital to support residents to receive a good quality of care within a framework of continuous improvement.

A Quality Indicator (QI) is usually calculated as a rate by counting how often an event (for example, physical restraint) occurs over a period of time in each residential facility.

Every three months residential facilities that have chosen to participate in the QI Program collect and submit their QI data to the Australian Government Department of Health (the department), which processes the data and generates a report about the indicators.

The QI Program complements but does not replace resident safety, risk, quality improvement, accreditation and innovation activities.

The QI Program does not and cannot say whether the care in the facility is right or wrong; or whether it is good or bad. It only tells us if rates change or are different in other residential facilities.

Information sources

Most residential facilities have a staff member who coordinates the collection and reporting of QI information (usually the manager or the quality coordinator).

Information is gathered from residents’ progress notes, care plans, assessments and audits. Privacy is protected as information submitted to the department does not contain identifying information about any resident.

Sometimes, additional information is obtained by talking with the clinical and care staff.

The role of general practitioners

The QIs are a reflection of how clinical and support staff provide care. General practitioner views are vital in order to interpret the data.

Any changes to improve resident care will also require the involvement of general practitioners.
Facilities participating in the QI Program need to respond proactively to QI information to continuously improve care.

**Improving quality of life for residents**

A Victorian survey that examined the use of the indicators in the Victorian Quality Indicator Program found these would trigger a review of care for the individual resident (62–79 per cent); staff practice (45–63 per cent) and the whole system (45–55 per cent). Following these reviews, beneficial changes in care for residents occurred in 58–75 per cent of occasions.

General practitioners have a vital contribution to make in examining practice to understand changes in the QI rates. The indicators directly or indirectly relate to clinical care and require medical expertise to interpret the data, reduce harm and improve care.

**Other areas of care**

The QIs used in the QI Program cover a limited number of areas which are high-priority risk areas for older people living in residential facilities.

There are many other important areas of risk such as constipation, pain, falls, use of medicines, depression, delirium and palliative care that facilities need to monitor through other programs.

It is not possible or desirable to measure every aspect of care through QIs.

The three indicators chosen for the initial implementation are important measures that have a broad impact across a number of other care areas. The QI Program will expand over time to include more QIs and measures of consumer experience and quality of life.

**Actions to take**

- Be familiar with the QIs and the QI Program.
- Ask questions.
- Ask for the QI reports.
- Ask to be involved with interpreting the information and contribute ideas to improve care.
- Be thorough, clear and accurate when completing documentation about care provided to each resident.
Information for the clinical and care team

About the Program

Across Australia every Commonwealth subsidised residential aged care facility (residential facility) is invited to participate in the National Aged Care Quality Indicator Program (QI Program).

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A Quality Indicator (QI) is usually calculated as a rate by counting how often an event (for example, physical restraint) occurs over a period of time in each residential facility.

Every three months residential facilities that have chosen to participate in the QI Program collect and submit QI data to the Australian Government Department of Health (the department), which processes the data and generates a report about the indicators.

The QI Program complements but does not replace other resident safety, risk, quality improvement, accreditation and innovation activities.

The QI Program does not and cannot say whether the care in the facility is right or wrong; or whether it is good or bad. It only tells us if rates change or are different in other residential facilities.

Information sources

Most residential facilities have a staff member who coordinates the collection and reporting of QI information (usually the manager or the quality coordinator).

Information is gathered from residents’ progress notes, care plans, assessments and audits. Privacy is protected as information submitted to the department does not contain identifying information about any resident.

Sometimes, additional information is obtained by talking with the clinical and care staff.

The role of the clinical and care team

QIs are a reflection of how the clinical and care team, and the facility, provide care.

The views of staff at the point of care need to be sought in order to sensibly interpret any changes in rates. In addition, the clinical and care team will need to action changes to improve resident care.
Improving quality of life for residents

Residential facilities participating in the QI Program can access quarterly reports from the department describing how the residential facility is performing in each of the QIs.

It is up to you, alongside the managers, executive, other health professionals and residents, to interpret and question the information, and decide what areas of improvement may be required.

For example, if a residential facility’s performance in the pressure injury indicator shows there are more pressure injuries than last year or there are more pressure injuries compared with the national average, this is an alert or a warning sign.

It should trigger a review of practice to understand why this change occurred. Exploring the reasons for this change provides an opportunity to improve care and reduce the incidence of pressure injuries.

Other areas of care

The QIs used in the QI Program cover a limited number of areas which are high-priority risk areas for older people living in residential facilities.

There are many other important areas of risk such as constipation, pain, falls, use of medicines, depression, delirium and palliative care that facilities need to monitor through other programs.

It is not possible or desirable to measure every aspect of care through QIs.

The three indicators chosen for the initial implementation are important measures that have a broad impact across a number of other care areas. The QI Program will expand over time to include more QIs and measures of consumer experience and quality of life.

Actions to take

- Be thorough, clear and accurate when completing documentation about care provided to each resident.
- Take special notice when one of the events described by the QI occurs, as this may be examined in detail later to understand a change in the QI rate.
- Be familiar with the QIs and the Program.
- Ask questions.
- Ask for the full series of QI reports.
- Ask to be involved with interpreting the information and contribute ideas to improve care.
- Ask for training about how to explain the reports to residents and families.
Information for residents and families

About the program

Across Australia every Commonwealth subsidised residential aged care facility (residential facility) is invited to participate in the National Aged Care Quality Indicator Program (QI Program).

The QI Program measures different aspects of care.

The specific indicators used in the QI Program for residential care are:

1: Pressure injuries
2: Use of physical restraint
3: Unplanned weight loss

These areas can all have serious and potentially catastrophic impacts on the physical, mental, emotional and spiritual health for residents. Monitoring and measuring performance in these areas is vital to support residents to receive a good quality of care and quality of life within a framework of continuous improvement.

A Quality Indicator (QI) is usually calculated as a rate by counting how often an event (for example, physical restraint) occurs over a period of time in each residential facility.

Every three months residential facilities that have chosen to participate in the QI Program collect and submit QI data to the Australian Government Department of Health (the department), which processes the data and generates a report about the indicators.

The QI Program complements but does not replace other resident safety, risk, quality improvement, accreditation and innovation activities.

The QI Program does not and cannot say whether the care in the facility is right or wrong; or whether it is good or bad. It only tells us if rates change or are different in other residential facilities.

Information sources

Most residential facilities have a staff member who coordinates the collection and reporting of QI information (usually the manager or the quality coordinator).

Information is gathered from residents’ progress notes, care plans, assessments and audits. Privacy is protected as information submitted to the department does not contain identifying information about any resident.

Sometimes, additional information is obtained by talking with the clinical and care staff.

The role of residents and families

The QIs help to improve care of residents. The views of residents, families and their advocates are vital to interpret the data and when implementing any changes.
Improving quality of life for residents

Residential facilities participating in the QI Program access quarterly reports from the department describing how the residential facility is performing in each of the QIs.

The managers, executive, care staff of the facility, and other health professionals (such as doctors) interpret and question the information and decide how improvements can be made.

For example, if a facility’s performance in the pressure injury indicator shows there are more pressure injuries than last year or there are more pressure injuries compared with the national average, this is an alert or a warning sign.

It should trigger a review of practice to understand why this change occurred. Exploring the reasons for this change provides an opportunity to improve care and reduce the incidence of pressure injuries.

This may include additional training for staff, purchasing new equipment and changing how care is delivered.

Other areas of care

The QIs used in the QI Program cover a limited number of areas which are high-priority risk areas for older people living in residential facilities.

There are many other important areas of risk such as constipation, pain, falls, use of medicines, depression, delirium and palliative care that facilities need to monitor through other programs.

It is not possible or desirable to measure every aspect of care through QIs.

The three indicators chosen for the initial implementation are important measures that have a broad impact across a number of other care areas. The QI Program will expand over time to include more QIs and measures of consumer experience and quality of life.

Actions to take

- Ask questions.
- Ask for the QI report.
- Ask staff to explain the report.
- Ask to be involved with interpreting the information and contribute ideas to improve care.
Information for board directors and executives

About the Quality Indicator (QI) Program

Across Australia every Commonwealth subsidised residential aged care facility (residential facility) is invited to participate in the National Aged Care Quality Indicator Program (QI Program).

The QI Program measures different aspects of care.

The specific indicators used in the QI Program for residential care are:

1: Pressure injuries
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3: Unplanned weight loss

These areas can all have serious and potentially catastrophic impacts on the physical, mental, emotional and spiritual health for residents. Monitoring and measuring performance in these areas is vital to support residents to receive a good quality of care and quality of life within a framework of continuous improvement.

A QI is usually calculated as a rate by counting how often an event (for example, physical restraint) occurs over a period of time in each residential facility. The rates for each QI are calculated at individual facility level, and an average is calculated across participating residential facilities on a national level.

Every three months residential facilities that have chosen to participate in the QI Program collect and submit QI data to the Australian Government Department of Health (the department), which processes the data and generates a report about the indicators.

The QI Program complements but does not replace other resident safety, risk, quality improvement, accreditation and innovation activities.

The QI Program does not and cannot say whether the care in the facility is right or wrong; or whether it is good or bad. It only tells us if rates change or are different in other residential facilities.

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Information is gathered from residents’ progress notes, care plans, assessments and audits. Privacy is protected as information submitted to the department does not contain identifying information about any resident.

Sometimes, additional information is obtained by talking with the clinical and care staff.

The role of the board and executive

The board and executive is responsible for the governance, leadership and oversight of safe, high quality resident care.
This includes ensuring that organisational responses to the quality data are appropriate, so:

- Be familiar with the QIs, the QI Program and any targets your facility may have set.
- Ensure your organisation is an active participant in the QI Program.
- Ask to see a full series of the QI reports, and ask questions.
- Question whether the data collection systems and supports available to staff are sufficient to ensure accurate and reliable information is being reported and acted on.
- Ensure that targets are set to determine priorities for action along with realistic timelines for achieving the desired level of performance. Optimal care requires setting an aspirational target, which requires planning and focused effort over time to achieve.
- Be aware that the resources provided by the department to assist facilities understand the QI Program include a risk management framework for each indicator to guide efforts towards improving care.

**Additional information**

The board and executive will need information beyond that provided by the QI Program.

The QIs cover a limited number of areas which are high-priority risk areas for older people living in residential facilities.

Other information about care integration and effectiveness, and person-centeredness will need to be sourced from other parts of your governance systems, as well as information about other common and equally clinical risk areas such as constipation, falls, use of medicines, pain management and palliative care.
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*Please note that except for these references marked with an asterisk, all other references are cited in the Victorian Department of Health 2015, Quality Indicators in public sector residential aged care services, Resource materials, January 2015 edition, Victorian Department of Health.

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All information in this publication is correct as of November 2015