



Australian Government

Department of Health and Aged Care

National Aged Care Mandatory Quality Indicator Program (QI Program) Manual 3.0 – Part A



National Aged Care Mandatory Quality Indicator Program Manual 3.0 – Part A

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

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

Assistance

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

Acknowledgements

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1.0 Introduction to the National Aged Care Mandatory Quality Indicator Program

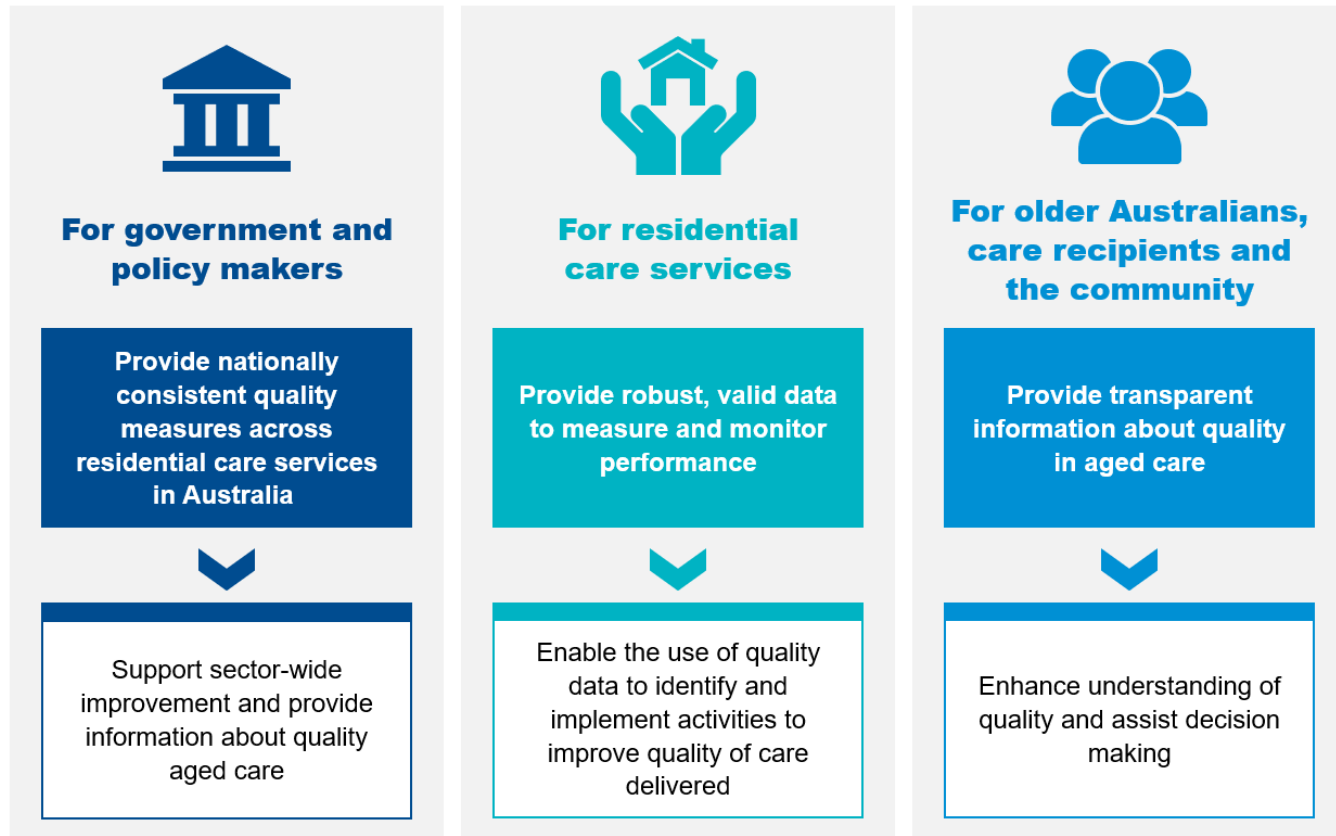
Participation in the National Aged Care Mandatory Quality Indicator Program (QI Program) has been a requirement for all approved providers of residential care services since 1 July 2019. The QI Program requires quarterly reporting against eleven quality indicators across crucial care areas — pressure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

1.1 QI Program objectives

The objectives of the QI Program are:

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

FIGURE 1: SUMMARY OF QI PROGRAM OBJECTIVES



2.0 Quality indicators in the QI Program

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

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

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

FIGURE 2: SUMMARY OF QI PROGRAM QUALITY INDICATORS

QI Program quality indicators	 Pressure injuries Percentage of care recipients with pressure injuries, reported against six pressure injury stages.	 Physical restraint Percentage of care recipients who were physically restrained.
 Unplanned weight loss - Percentage of care recipients who experienced significant unplanned weight loss (5% or more). - Percentage of care recipients who experienced consecutive unplanned weight loss.	 Falls and major injury - Percentage of care recipients who experienced one or more falls. - Percentage of care recipients who experienced one or more falls resulting in major injury.	 Medication management - Percentage of care recipients who were prescribed nine or more medications. - Percentage of care recipients who received antipsychotic medications.
 Activities of daily living Percentage of care recipients who experienced a decline in activities of daily living.	 Incontinence care Percentage of care recipients who experienced incontinence associated dermatitis.	 Hospitalisation Percentage of care recipients who had one or more emergency department presentations.
 Workforce Percentage of staff turnover.	 Consumer experience Percentage of care recipients who report 'good' or 'excellent' experience of the service.	 Quality of life Percentage of care recipients who report 'good' or 'excellent' quality of life.

2.1 Percentage value for quality indicators

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

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

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

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

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

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

The QI Program involves specific methods for collecting, recording, submitting, and interpreting information about the quality indicators. In accordance with the Aged Care Act, residential care services must collect data consistently using the methods prescribed in the *National Aged Care Mandatory Quality Indicator Program Manual 3.0 – Part A* (Manual).

Residential care services must record and submit their quality indicator data into the My Aged Care provider portal (provider portal). Further information is outlined in sections 8 to 20 of this Manual.

The provider portal will:

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

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

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

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

Further guidance relating to the provider portal is in QI Program Manual 3.0 Part C.

3.0 Quality indicator data submission

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

Approved providers must submit quality indicator data into the provider portal no later than the **21st day of the month after the end of each quarter**. Further guidance relating to quality indicator data submission is available in QI Program Manual 3.0 Part C.

FIGURE 3: DATES FOR SUBMISSION OF QUALITY INDICATOR DATA



4.0 Data recording templates

A data recording template is available for each quality indicator to automatically calculate and summarise the quality indicator data to enter and submit through the provider portal's *Quality Indicator* tile. QI Program Data Recording Templates are available on the department and Aged Care Quality and Safety Commission websites. Instructions on how to use the data recording template are provided within the templates.

5.0 Measurement and assessment – data collection for quality indicators

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

6.0 Record keeping

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

7.0 Definitions

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

TABLE 1: QI PROGRAM DEFINITIONS

Term	Definition
Assessment period	The period of time where services are required to collect and record data for each quality indicator. For some quality indicators, this involves retrospective audit and for others it involves a point in time observation assessment.
Collection date	The day on which care recipient data is captured, for each quality indicator assessment period.
Exclusions	Care recipients who, on the basis of meeting stipulated criteria, are no longer eligible to be included in the total counts for each quality indicator. Consequently, exclusions are deducted from the population assessed for the quality indicator and the resulting percentage value reported. Where multiple exclusion reasons apply to any care recipient who is excluded from being assessed for a quality indicator, the primary reason should be applied and reported. Secondary reasons are not required to be reported. The exception to this definition is an exclusion for the incontinence care quality indicator. Care recipients who did not have incontinence, are not eligible to be included in the population assessed for incontinence associated dermatitis. However, these care recipients do continue to be included in the total count assessed for the incontinence care quality indicator.



8.0 Pressure injuries

8.1 Overview of pressure injuries

A pressure injury is a localised injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure, shear, or a combination of these factors¹. Pressure injuries are potentially life threatening, decrease the care recipient's quality of life, and are expensive to manage. Regular monitoring for pressure injuries is important because pressure injuries may develop rapidly and are a painful, costly, and often preventable complication of which many older Australians are at risk.

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

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

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

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

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



TABLE 2: PRESSURE INJURIES QUALITY INDICATOR OVERVIEW



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

COLLECTION

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

QUALITY INDICATOR REPORTING

- Care recipients with one or more pressure injuries
- Care recipients with one or more pressure injuries reported against each of the six pressure injury stages:
 - Stage 1 Pressure Injury
 - Stage 2 Pressure Injury
 - Stage 3 Pressure Injury
 - Stage 4 Pressure Injury
 - Unstageable Pressure Injury
 - Suspected Deep Tissue Injury

ADDITIONAL REPORTING

- Care recipients assessed for pressure injuries
- Care recipients with one or more pressure injuries acquired outside of the service during the quarter
- Care recipients with one or more pressure injuries acquired outside of the service during the quarter, reported against each of the six pressure injury stages:
 - Stage 1 Pressure Injury
 - Stage 2 Pressure Injury
 - Stage 3 Pressure Injury
 - Stage 4 Pressure Injury
 - Unstageable Pressure Injury
 - Suspected Deep Tissue Injury

Exclusions:

- Care recipients who withheld consent to undergo an observation assessment for pressure injuries for the entire quarter
- Care recipients who were absent from the service for the entire quarter



8.2 Key terms for pressure injuries

A **pressure injury** is a localised injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure, shear, or a combination of these factors⁴.

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

TABLE 3: STAGES OF PRESSURE INJURIES

STAGE 1 PRESSURE INJURY

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

STAGE 2 PRESSURE INJURY

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

STAGE 3 PRESSURE INJURY

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

STAGE 4 PRESSURE INJURY

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

UNSTAGEABLE PRESSURE INJURY

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

SUSPECTED DEEP TISSUE INJURY

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

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



8.3 Measurements and assessments for pressure injuries

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

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

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

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

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

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

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

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

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



- Stage 4 Pressure Injury
- Unstageable Pressure Injury
- Suspected Deep Tissue Injury

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

8.3.1 Inclusions for pressure injuries

All care recipients must be assessed for pressure injuries except those listed in 8.3.2. *Exclusions for pressure injuries.*

8.3.2 Exclusions for pressure injuries

Care recipients who:

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

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

8.4 Data reporting for pressure injuries

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

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



TABLE 4: REQUIREMENTS FOR DATA REPORTING ON PRESSURE INJURIES

1	Number of care recipients assessed for pressure injuries. <i>Note: All care recipients must be assessed for pressure injuries except those listed in 8.3.2. Exclusions for pressure injuries.</i>	
2	Number of care recipients excluded because they withheld consent to undergo an observation assessment for pressure injuries for the entire quarter.	
3	Number of care recipients excluded because they were absent from the service for the entire quarter.	
4	Number of care recipients with one or more pressure injuries. <i>Note: This is the total number of care recipients with one or more pressure injuries, including those acquired outside of the service.</i>	
5	Number of care recipients with one or more pressure injuries, reported against each of the six pressure injury stages. <i>Note: The care recipient may have more than one pressure injury. In this case all pressure injuries must be assessed and the presence of a pressure injury at each stage (one or more) must then be recorded against each of the six stages.</i>	
6	Number of care recipients with one or more pressure injuries acquired outside of the service during the quarter.	
7	Number of care recipients with one or more pressure injuries acquired outside of the service during the quarter, reported against each of the six pressure injury stages. <i>Note: The care recipient may have more than one pressure injury acquired outside the service. In this case all pressure injuries acquired outside the service must be assessed and the presence of a pressure injury at each stage (one or more) must then be recorded against each of the six stages.</i>	

8.5 How to report pressure injuries

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

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

8.6 Additional resources for pressure injuries

More information and resources related to pressure injuries are available at www.health.gov.au and in QI Program Manual 3.0 Part B.



9.0 Physical restraint

9.1 Key terms for physical restraint

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

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

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



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

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

TABLE 5: PHYSICAL RESTRAINT QUALITY INDICATOR OVERVIEW

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



9.2 Key terms for physical restraint

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

- mechanical restraint is a practice or intervention that is, or that involves, the use of a device to prevent, restrict or subdue a care recipient's movement for the primary purpose of influencing the care recipient's behaviour, but does not include the use of a device for therapeutic or non-behavioural purposes in relation to the care recipient
- physical restraint is a practice or intervention that:
 - is or involves, the use of physical force to prevent, restrict or subdue movement of a care recipient's body, or part of a care recipient's body, for the primary purpose of influencing the care recipient's behaviour; but
 - does not include the use of a hands-on technique in a reflexive way to guide or redirect the care recipient away from potential harm or injury if it is consistent with what could reasonably be considered to be the exercise of care towards the care recipient
- environmental restraint is a practice or intervention that restricts, or that involves restricting, a care recipient's free access to all parts of the care recipient's environment (including items and activities) for the primary purpose of influencing the care recipient's behaviour
- seclusion is a practice or intervention that is, or that involves, the solitary confinement of a care recipient in a room or a physical space at any hour of the day or night where:
 - i. voluntary exit is prevented or not facilitated; or
 - ii. it is implied that voluntary exit is not permitted;for the primary purpose of influencing the care recipient's behaviour.

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

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

9.3 Measurements and assessments for physical restraint

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

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

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

Note: *Physical restraint must be recorded, even if a care recipient or their representative have provided consent to the use of the restraint.*



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

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

9.3.1 Inclusions for physical restraint

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

9.3.2 Exclusions for physical restraint

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

9.4 Data reporting for physical restraint

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

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

TABLE 6: REQUIREMENTS FOR DATA REPORTING ON PHYSICAL RESTRAINT

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

9.5 How to report physical restraint

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



9.6 Additional resources for physical restraint

More information and resources related to physical restraint are available at www.health.gov.au and in QI Program Manual 3.0 Part B.



10.0 Unplanned weight loss – significant

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

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

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

10.1 Overview of significant unplanned weight loss

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

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

TABLE 7: SIGNIFICANT UNPLANNED WEIGHT LOSS QUALITY INDICATOR OVERVIEW

 Percentage of care recipients who experienced significant unplanned weight loss (5% or more)	COLLECTION • The weight of each care recipient is collected in the last month (finishing weight) of the quarter and compared to their weight record in the last month of the previous quarter (previous weight) to determine percentage of weight loss
	QUALITY INDICATOR REPORTING • Care recipients who experienced significant unplanned weight loss (5% or more)
	ADDITIONAL REPORTING • Care recipients assessed for significant unplanned weight loss <i>Exclusions:</i> • Care recipients who withheld consent to be weighed • Care recipients who are receiving end-of-life care • Care recipients who did not have the required weights recorded (e.g. previous and/or finishing weight) and comments providing explanation as to why the weight recording/s are absent



10.2 Key terms for significant unplanned weight loss

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

Note: *If a care recipient has a written record from a medical doctor or dietitian, which includes intentional weight loss (e.g. body fat or fluid), this weight loss will not be counted as unplanned weight loss, because it does not meet the definition.*

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

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

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

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

10.3 Measurements and assessments for significant unplanned weight loss

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

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

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

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

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

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

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

3. Record the care recipients excluded because they withheld consent to be weighed on the finishing weight collection date.
4. Record the care recipients excluded because they are receiving end-of-life care.
5. Record the care recipients excluded because they did not have the required weights recorded (e.g. previous and/or finishing weight). Include comments as to why the weight recording/s are absent (e.g. the care recipient was hospitalised).



6. For each care recipient who provided their consent, compare their finishing weight from the current quarter with their previous weight (finishing weight from the previous quarter) and calculate the percentage of weight loss (formula provided below). The percentage of unplanned weight loss can be calculated using an automated template or the following formula:

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

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

10.3.1 Inclusions for significant unplanned weight loss

All care recipients must be assessed for significant unplanned weight loss except those listed in 10.3.2. *Exclusions for significant unplanned weight loss.*

10.3.2 Exclusions for significant unplanned weight loss

Care recipients who:

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

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

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

10.4 Data reporting for significant unplanned weight loss

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

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



TABLE 8: REQUIREMENTS FOR DATA REPORTING ON SIGNIFICANT UNPLANNED WEIGHT LOSS

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

10.5 How to report significant unplanned weight loss

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

10.6 How to record information in the My Aged Care provider portal

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

10.7 Additional resources for significant unplanned weight loss

More information and resources related to significant unplanned weight loss are available at www.health.gov.au and in QI Program Manual 3.0 Part B.



IMPORTANT NOTE

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

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



11.0 Unplanned weight loss – consecutive

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

1. significant unplanned weight loss (see Section 10.0 of this Manual), and
2. consecutive unplanned weight loss (this Section).

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

11.1 Overview of consecutive unplanned weight loss

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

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

TABLE 9: CONSECUTIVE UNPLANNED WEIGHT LOSS QUALITY INDICATOR OVERVIEW

 Percentage of care recipients who experienced consecutive unplanned weight loss	COLLECTION • Three monthly weights are collected for each care recipient every quarter and are compared against each other, as well as the finishing weight from the previous quarter (previous weight), to determine consecutive unplanned weight loss
	QUALITY INDICATOR REPORTING • Care recipients who experienced consecutive unplanned weight loss of any amount
	ADDITIONAL REPORTING • Care recipients assessed for consecutive unplanned weight loss <i>Exclusions:</i> • Care recipients who withheld consent to be weighed on the starting, middle and/or finishing weight collection dates • Care recipients who are receiving end-of-life care • Care recipients who did not have the required weights recorded (e.g. previous, starting, middle and/or finishing weights) and comments providing explanation as to why the weight recording/s are absent



11.2 Key terms for consecutive unplanned weight loss

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

Note: *If a care recipient has a written record from a medical doctor or dietitian, which includes intentional weight loss (e.g. body fat or fluid), this weight loss will not be counted as unplanned weight loss because it does not meet the definition.*

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

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

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

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

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

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

11.3 Measurements and assessments for consecutive unplanned weight loss

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

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

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

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

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

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

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

3. In the second month of the quarter, collect and record the middle weight of each care recipient residing at the service, using a calibrated scale.



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

11.3.1 Inclusions for consecutive unplanned weight loss

All care recipients must be assessed for unplanned weight loss except those listed in 11.3.2. *Exclusions for consecutive unplanned weight loss.*

11.3.2 Exclusions for consecutive unplanned weight loss

Care recipients who:

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

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

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

11.4 Data reporting for consecutive unplanned weight loss

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

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



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

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

11.5 How to report consecutive unplanned weight loss

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

11.6 How to record information in the My Aged Care provider portal

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

11.7 Additional resources for consecutive unplanned weight loss

More information and resources related to consecutive unplanned weight loss are available at www.health.gov.au and in QI Program Manual 3.0 Part B.



IMPORTANT NOTE

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

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



12.0 Falls and major injury

12.1 Overview of falls and major injury

A fall is an event that results in a person coming to rest inadvertently on the ground or floor or other lower level. A fall resulting in major injury is a fall that meets this definition and results in one or more of the following; bone fractures, joint dislocations, closed head injuries with altered consciousness and/or subdural haematoma.⁵

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

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

TABLE 11: FALLS AND MAJOR INJURY QUALITY INDICATOR OVERVIEW

 Percentage of care recipients who experienced one or more falls Percentage of care recipients who experienced one or more falls resulting in major injury	COLLECTION A single review of the care records of each care recipient for the entire quarter
	QUALITY INDICATOR REPORTING - Care recipients who experienced one or more falls at the service during the quarter - Care recipients who experienced one or more falls at the service resulting in major injury during the quarter
	ADDITIONAL REPORTING - Care recipients assessed for falls and major injury <i>Exclusions:</i> - Care recipients who were absent from the service for the entire quarter

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



12.2 Key terms for falls and major injury

For the purposes of the QI Program, a **fall** is defined as an event that results in a person coming to rest inadvertently on the ground or floor or other lower level.⁶ Falls resulting in major injury that occurred while the care recipient was away from the service and not under direct supervision of service staff are not included.

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

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

12.3 Measurements and assessments for falls and major injury

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

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

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

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

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

12.3.1 Inclusions for falls and major injury

All care recipients must be assessed for falls and major injury except those listed in 12.3.2. *Exclusions for falls and major injury.*

12.3.2 Exclusions for falls and major injury

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

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

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



12.4 Data reporting for falls and major injury

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

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

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

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

12.5 How to report falls and major injury

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

12.6 Additional resources for falls and major injury

More information and resources related to falls and major injury are available at www.health.gov.au and in QI Program Manual 3.0 Part B.



13.0 Medication management – polypharmacy

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

1. medication management – polypharmacy (this section), and
2. medication management – antipsychotics (see Section 14.0 of this Manual).

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

13.1 Overview of polypharmacy

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

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

TABLE 13: MEDICATION MANAGEMENT – POLYPHARMACY QUALITY INDICATOR OVERVIEW

 Percentage of care recipients who were prescribed nine or more medications	COLLECTION • A single review of medication charts and/or administration records for each care recipient on a selected collection date every quarter
	QUALITY INDICATOR REPORTING • Care recipients who were prescribed nine or more medications
	ADDITIONAL REPORTING • Care recipients assessed for polypharmacy • Collection date <i>Exclusions:</i> • Care recipients admitted in hospital on the collection date



13.2 Key terms for polypharmacy

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

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

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

- Lotions, creams or ointments used in skin and wound care;
- Dietary supplements, including those containing vitamins;
- Short-term medications, such as antibiotics or temporary eye drops; and
- PRN medications.

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

13.3 Measurements and assessments for polypharmacy

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

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

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

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

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

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

13.3.1 Inclusions for polypharmacy

All care recipients must be assessed for medication management except those listed in 13.3.2. *Exclusions for polypharmacy.*

13.3.2 Exclusions for polypharmacy

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



13.4 Data reporting for polypharmacy

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

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

TABLE 14: REQUIREMENTS FOR DATA REPORTING ON POLYPHARMACY

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

13.5 How to report polypharmacy

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

13.6 Additional resources for polypharmacy

More information and resources related to polypharmacy are available at www.health.gov.au and in QI Program Manual 3.0 Part B.



14.0 Medication management – antipsychotics

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

1. medication management – polypharmacy (see Section 13.0 of this Manual), and
2. medication management – antipsychotics (this section).

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

14.1 Overview of antipsychotics

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

TABLE 15: MEDICATION MANAGEMENT – ANTIPSYCHOTICS QUALITY INDICATOR OVERVIEW

 Percentage of care recipients who received antipsychotic medications	COLLECTION
	• A seven-day medication chart and/or administration record review for each care recipient every quarter
	QUALITY INDICATOR REPORTING
	• Care recipients who received an antipsychotic medication
	ADDITIONAL REPORTING
	• Care recipients assessed for antipsychotic medications • Care recipients who received an antipsychotic medication for a diagnosed condition of psychosis • Collection date
	<i>Exclusions:</i>
	• Care recipients who were admitted in hospital for the entire seven-day assessment period



14.2 Key terms for antipsychotics

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

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

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

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

14.3 Measurements and assessments for antipsychotics

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

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

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

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

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

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

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

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

14.3.1 Inclusions for antipsychotics

All care recipients must be assessed for medication management except those listed in 14.3.2. *Exclusions for antipsychotics.*



14.3.2 Exclusions for antipsychotics

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

14.4 Data reporting for antipsychotics

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

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

TABLE 16: REQUIREMENTS FOR DATA REPORTING ON ANTIPSYCHOTICS

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

14.5 How to report antipsychotics

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

14.6 Additional resources for antipsychotics

More information and resources related to antipsychotics are available at www.health.gov.au and in QI Program Manual 3.0 Part B.



15.0 Activities of daily living

15.1 Overview of activities of daily living

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

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

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

TABLE 17: ACTIVITIES OF DAILY LIVING QUALITY INDICATOR OVERVIEW

 Percentage of care recipients who experienced a decline in activities of daily living	COLLECTION A single assessment for each care recipient is completed around the same time every quarter and compared to their ADL assessment total score in the previous quarter to determine decline
	QUALITY INDICATOR REPORTING Care recipients who experienced a decline in their ADL assessment total score of one or more points
	ADDITIONAL REPORTING - Care recipients assessed for ADL function - Care recipients with an ADL assessment total score of zero in the previous quarter <i>Exclusions:</i> - Care recipients who are receiving end-of-life care - Care recipients who were absent from the service for the entire quarter - Care recipients who did not have an ADL assessment total score recorded for the previous quarter and comments providing explanation as to why recording is absent

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



15.2 Key terms for activities of daily living

The Barthel Index of Activities of Daily Living assessment tool (included in [Appendix A](#)) is comprised of 10 items. For each item, choose the statement most closely corresponding to a care recipient's current level of ability. The score for each statement is added together to give the ADL assessment total score.

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

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

15.3 Measurements and assessments for activities of daily living

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

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

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

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

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

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

15.3.1 Inclusions for activities of daily living

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



15.3.2 Exclusions for activities of daily living

Care recipients who:

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

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

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

15.4 Data reporting for activities of daily living

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

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

TABLE 18: REQUIREMENTS FOR DATA REPORTING ON ACTIVITIES OF DAILY LIVING

1	Number of care recipients assessed for ADL function. <i>Note: All care recipients must be assessed for ADL function, except for those listed in 15.3.2 Exclusions for activities of daily living.</i>	
2	Number of care recipients excluded because they were receiving end-of-life care.	
3	Number of care recipients excluded because they were absent from the service for the entire quarter.	
4	Number of care recipients excluded because they did not have an ADL assessment total score recorded for the previous quarter. Include comments as to why the previous recording is absent.	
5	Number of care recipients with an ADL assessment total score of zero in the previous quarter.	
6	Number of care recipients who experienced a decline in ADL assessment total score of one or more points.	

15.5 How to report activities of daily living

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



15.6 How to record information in My Aged Care provider portal

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

15.7 Additional resources for activities of daily living

More information and resources related to ADLs are included in [Appendix A](#), and are available at www.health.gov.au and in QI Program Manual 3.0 Part B.



16.0 Incontinence care

16.1 Overview of incontinence care

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

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

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

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

TABLE 19: INCONTINENCE CARE QUALITY INDICATOR OVERVIEW

 Percentage of care recipients who experienced incontinence associated dermatitis	COLLECTION A single assessment for each care recipient, around the same time every quarter as part of routine care
	QUALITY INDICATOR REPORTING - Care recipients with incontinence who experienced IAD - Care recipients who experienced IAD, reported against each of the four sub-categories: 1A: Persistent redness without clinical signs of infection 1B: Persistent redness with clinical signs of infection 2A: Skin loss without clinical signs of infection 2B: Skin loss with clinical signs of infection
	ADDITIONAL REPORTING - Care recipients assessed for incontinence care - Care recipients with incontinence <i>Exclusions for incontinence care:</i> - Care recipients who were absent from the service for the entire quarter <i>Exclusions for IAD assessment:</i> - Care recipients who did not have incontinence

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

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



16.2 Key terms for incontinence care

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

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

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

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

TABLE 20: SUB-CATEGORIES OF IAD

CATEGORY 1 PERSISTENT REDNESS

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

CATEGORY 2 SKIN LOSS

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

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

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

16.3 Measurements and assessments for incontinence care

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

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

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

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

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

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

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



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

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

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

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

16.3.1 Inclusions for incontinence care

All care recipients must be assessed for incontinence care except for those listed in 16.3.2 Exclusions for incontinence care.

16.3.2 Exclusions for incontinence care

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

16.3.3 Exclusions for IAD assessment

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

16.4 Data reporting for incontinence care

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

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



TABLE 21: REQUIREMENTS FOR DATA REPORTING ON INCONTINENCE CARE

1	Number of care recipients assessed for incontinence care. <i>Note: All care recipients must be assessed for incontinence care except for those listed in 16.3.2 Exclusions for incontinence care.</i>	
2	Number of care recipients excluded because they were absent from the service for the entire quarter.	
3	Number of care recipients excluded from IAD assessment because they did not have incontinence.	
4	Number of care recipients with incontinence.	
5	Number of care recipients with incontinence who experienced IAD.	
6	Number of care recipients with incontinence who experienced IAD, reported against each of the four IAD sub-categories: • 1A: Persistent redness without clinical signs of infection • 1B: Persistent redness with clinical signs of infection • 2A: Skin loss without clinical signs of infection • 2B: Skin loss with clinical signs of infection.	

16.5 How to report incontinence care

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

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

16.6 Additional resources for incontinence care

More information and resources related to incontinence care are included in [Appendix B](#), and are available at www.health.gov.au and in QI Program Manual 3.0 Part B.



17.0 Hospitalisation

17.1 Overview of hospitalisation

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

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

TABLE 22: HOSPITALISATION QUALITY INDICATOR OVERVIEW

 Percentage of care recipients who had one or more emergency department presentations	COLLECTION
	• A single review of the care records for each care recipient for the entire quarter
	QUALITY INDICATOR REPORTING
	• Care recipients who had one or more emergency department presentations during the quarter
	ADDITIONAL REPORTING
	• Care recipients assessed for hospitalisation • Care recipients who had one or more emergency department presentations or hospital admissions during the quarter
	<i>Exclusions:</i>
	• Care recipients who were absent from the service for the entire quarter



17.2 Key terms for hospitalisation

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

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

17.3 Measurements and assessments for hospitalisation

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

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

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

17.3.1 Inclusions for hospitalisation

All care recipients must be assessed for hospitalisation except those listed in *17.3.2 Exclusions for hospitalisation*.

17.3.2 Exclusions for hospitalisation

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

17.4 Data reporting for hospitalisation

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

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



TABLE 23: REQUIREMENTS FOR DATA REPORTING ON HOSPITALISATION

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

17.5 How to report hospitalisation

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

17.6 Additional resources for hospitalisation

More information and resources related to hospitalisation are available at www.health.gov.au and in QI Program Manual 3.0 Part B.



18.0 Workforce

18.1 Overview of workforce

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

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

TABLE 24: WORKFORCE QUALITY INDICATOR OVERVIEW

 Percentage of staff turnover	COLLECTION • A single review of staff records
	QUALITY INDICATOR REPORTING • Staff who were employed at the start of the quarter as: – service managers – nurse practitioners or registered nurses – enrolled nurses – personal care staff or assistants in nursing • Staff who stopped working during the quarter as: – service managers – nurse practitioners or registered nurses – enrolled nurses – personal care staff or assistants in nursing
	ADDITIONAL REPORTING • Staff who worked any hours during the previous quarter as: – service managers – nurse practitioners or registered nurses – enrolled nurses – personal care staff or assistants in nursing



18.2 Key terms for workforce

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

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

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

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

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

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

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

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

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

18.3 Measurements and assessments for workforce

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

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

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



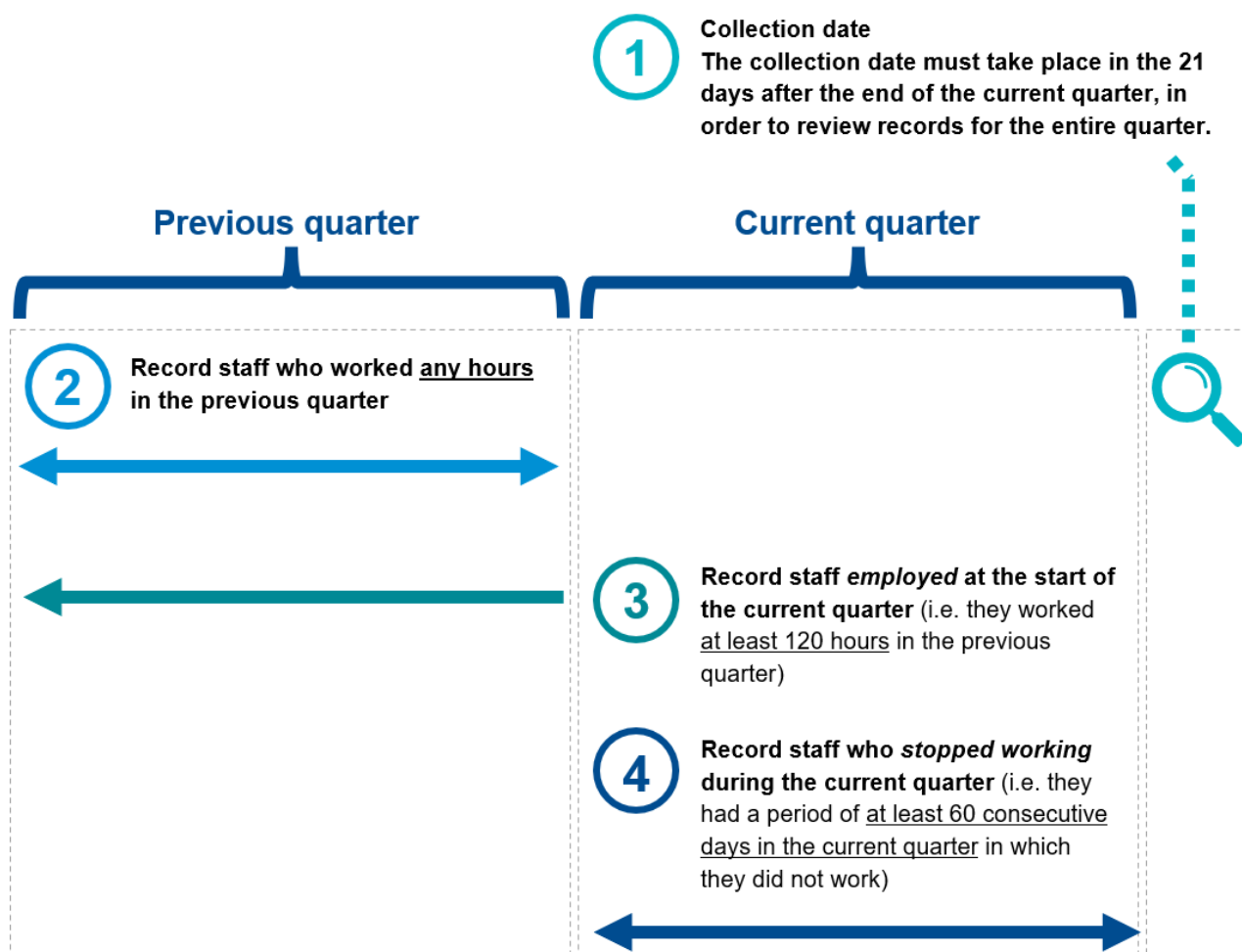
at the start of the current quarter (i.e. they worked at least 120 hours at the service in the previous quarter).

Note: Refer to 18.2 Key terms for workforce for the definition of 'employed staff'.

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

Note: Refer to 18.2 Key terms for workforce for the definition of 'staff who stopped working'.

FIGURE 4: SUMMARY OF DATA COLLECTION STEPS FOR WORKFORCE



18.3.1 Inclusions for workforce

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

Note: Refer to 18.2 Key terms for workforce.

18.3.2 Exclusions for workforce

Nil.



18.4 Data reporting for workforce

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

TABLE 25: REQUIREMENTS FOR DATA REPORTING ON WORKFORCE

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



18.5 How to report workforce

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

18.6 Additional resources for workforce

More information and resources related to workforce are available at www.health.gov.au and in QI Program Manual 3.0 Part B.



19.0 Consumer experience

19.1 Overview of consumer experience

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

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

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

TABLE 26: CONSUMER EXPERIENCE QUALITY INDICATOR OVERVIEW

 Percentage of care recipients who report 'good' or 'excellent' experience of the service	COLLECTION
	A consumer experience assessment must be offered to each care recipient for completion, around the same time every quarter
	QUALITY INDICATOR REPORTING
	- Care recipients who reported consumer experience through each completion mode of the QCE-ACC (self-completion, interviewer facilitated completion or proxy-completion), scored against the categories: 'Excellent' (care recipients who score between 22–24) 'Good' (care recipients who score between 19–21)
	ADDITIONAL REPORTING
	- Care recipients who were offered a consumer experience assessment for completion - Care recipients who reported consumer experience through each completion mode of the QCE-ACC (self-completion, interviewer facilitated completion or proxy-completion), scored against the categories: 'Moderate' (care recipients who score between 14–18) 'Poor' (care recipients who score between 8–13) 'Very poor' (care recipients who score between 0–7)
	Exclusions:
	- Care recipients who were absent from the service for the entire quarter - Care recipients who did not choose to complete the consumer experience assessment for the entire quarter

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



19.2 Key terms for consumer experience

The Quality of Care Experience Aged Care Consumers[®] (QCE-ACC) tool asks care recipients to indicate their quality of care experience by selecting the most appropriate statement using a five-point scale from 'never' to 'always' for each of the six survey questions, see [Appendix C](#).

The care recipient's scores for each of the six questions is added together to give a total score, and is then assigned to one of five categories describing overall consumer experience:

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

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

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

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

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

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

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

19.3 Measurements and assessments for consumer experience

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

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

1.

- a. Offer the QCE-ACC Self-Complete Version for self-completion to all suitable care recipients at the service at around the same time every quarter. The QCE-ACC Self-Complete Version can be self-completed by care recipients with no or mild cognitive impairment.
- b. Arrange interviewer facilitated completion for all care recipients requiring assistance to complete the QCE-ACC (e.g. where the care recipient requires support with reading the questions or writing



responses) at around the same time every quarter using the QCE-ACC Interviewer Facilitated Version.

- c. Arrange proxy-completion for all care recipients who cannot complete the QCE-ACC through self-completion or interviewer facilitated completion (e.g. due to moderate or severe cognitive impairment) at around the same time every quarter using the QCE-ACC Proxy Version.
2. Record the care recipients excluded because they were absent from the service for the entire quarter.
3. Record the care recipients excluded because they did not choose to complete the QCE-ACC for the entire quarter.

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

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

19.3.1 Inclusions for consumer experience

All care recipients must be assessed for consumer experience except for those listed in 19.3.2 *Exclusions for consumer experience*.

19.3.2 Exclusions for consumer experience

Care recipients who:

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

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

19.4 Data reporting for consumer experience

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

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



TABLE 27: REQUIREMENTS FOR DATA REPORTING ON CONSUMER EXPERIENCE

1	Number of care recipients offered a consumer experience assessment through self-completion, interviewer facilitated completion or proxy-completion. <i>Note: All care recipients must be assessed for consumer experience except for those listed in 19.3.2 Exclusions for consumer experience.</i>	
2	Number of care recipients excluded because they were absent from the service for the entire quarter.	
3	Number of care recipients excluded because they did not choose to complete the QCE-ACC for the entire quarter.	
4	Number of care recipients who reported consumer experience through each completion mode of the QCE-ACC (self-completion, interviewer facilitated completion, or proxy-completion), scored against the five categories: • ‘Excellent’ (care recipients who score between 22–24) • ‘Good’ (care recipients who score between 19–21) • ‘Moderate’ (care recipients who score between 14–18) • ‘Poor’ (care recipients who score between 8–13) • ‘Very poor’ (care recipients who score between 0–7).	

19.5 How to report consumer experience

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

19.6 Additional resources for consumer experience

More information and resources related to consumer experience are included in [Appendix C](#), and are available at www.health.gov.au and in QI Program Manual 3.0 Part B.



20.0 Quality of life

20.1 Overview of quality of life

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

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

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

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

TABLE 28: QUALITY OF LIFE QUALITY INDICATOR OVERVIEW

 Percentage of care recipients who report 'good' or 'excellent' quality of life	COLLECTION A quality of life assessment must be offered to each care recipient for completion, around the same time every quarter
	QUALITY INDICATOR REPORTING - Care recipients who reported quality of life through each completion mode of the QOL-ACC (self-completion, interviewer facilitated completion and proxy-completion), scored against the categories: 'Excellent' (care recipients who score between 22–24) 'Good' (care recipients who score between 19–21)
	ADDITIONAL REPORTING - Care recipients who were offered a quality of life assessment for completion - Care recipients who reported quality of life through each completion mode of the QOL-ACC (self-completion, interviewer facilitated completion and proxy-completion), scored against the categories: 'Moderate' (care recipients who score between 14–18) 'Poor' (care recipients who score between 8–13) 'Very poor' (care recipients who score between 0–7) <i>Exclusions:</i> - Care recipients who were absent from the service for the entire quarter - Care recipients who did not choose to complete the quality of life assessment for the entire quarter

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



20.2 Key terms for quality of life

The Quality of Life Aged Care Consumers© (QOL-ACC) tool asks care recipients to indicate their quality of life by selecting the most appropriate statement using a five-point scale from 'none of the time' to 'all of the time' in each of the six survey questions, see [Appendix D](#).

The care recipient's scores for each of the six questions is added together to give a total score, and is then assigned to one of five categories describing overall quality of life:

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

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

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

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

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

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

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

20.3 Measurements and assessments for quality of life

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

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

1.
 - a. Offer the QOL-ACC Self-Complete Version for self-completion to all suitable care recipients at the service at around the same time every quarter. The QOL-ACC Self-Complete Version can be self-completed by care recipients with no or mild cognitive impairment.
 - b. Arrange interviewer facilitated completion for all care recipients requiring assistance to complete the QOL-ACC (e.g. where the care recipient requires support with reading the questions or writing responses) at around the same time every quarter using the QOL-ACC Interviewer Facilitated Version.



- c. Arrange proxy-completion for all care recipients who cannot complete the QOL-ACC through self-completion or interviewer facilitated completion (e.g. due to moderate or severe cognitive impairment) at around the same time every quarter using the QOL-ACC Proxy Version.
2. Record the care recipients excluded because they were absent from the service for the entire quarter.
3. Record the care recipients excluded because they did not choose to complete the QOL-ACC for the entire quarter.

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

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

20.3.1 Inclusions for quality of life

All care recipients must be assessed for quality of life except for those listed in 20.3.2 *Exclusions for quality of life*.

20.3.2 Exclusions for quality of life

Care recipients who:

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

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

20.4 Data reporting for quality of life

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

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



TABLE 29: REQUIREMENTS FOR DATA REPORTING ON QUALITY OF LIFE

1	Number of care recipients offered a quality of life assessment through self-completion, interviewer facilitated completion or proxy-completion. <i>Note: All care recipients must be assessed for quality of life except for those listed in 20.3.2 Exclusions for quality of life.</i>	
2	Number of care recipients excluded because they were absent from the service for the entire quarter.	
3	Number of care recipients excluded because they did not choose to complete the QOL-ACC for the entire quarter.	
4	Number of care recipients who reported quality of life through each completion mode of the QOL-ACC (self-completion, interviewer facilitated completion or proxy-completion), scored against the five categories: • ‘Excellent’ (care recipients who score between 22–24) • ‘Good’ (care recipients who score between 19–21) • ‘Moderate’ (care recipients who score between 14–18) • ‘Poor’ (care recipients who score between 8–13) • ‘Very poor’ (care recipients who score between 0–7).	

20.5 How to report quality of life

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

20.6 Additional resources for quality of life

More information and resources related to quality of life are included in [Appendix D](#), and are available at www.health.gov.au and in QI Program Manual 3.0 Part B.

Appendix A

Barthel Index of Activities of Daily Living

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

Instructions¹⁴

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

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

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

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

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

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

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

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

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

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

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

Barthel Index of Activities of Daily Living

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

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

Bowels	Score	Transfer	Score
0. Incontinent (or needs to be given enemata)		0. Unable – no sitting balance	
1. Occasional accident (once per week)		1. Major help (one or two people, physical), can sit	
2. Continent		2. Minor help (verbal or physical)	
		3. Independent	
Bladder		Mobility	
0. Incontinent, or catheterised and unable to manage		0. Immobile	
1. Occasional accident (max once per 24 hours)		1. Wheelchair independent, including corners, etc.	
2. Continent (for over 7 days)		2. Walks with help of one person (verbal or physical)	
		3. Independent (but may use aid e.g. walking stick)	
Grooming		Dressing	
0. Needs help with personal care		0. Dependent	
1. Independent face / hair/ teeth / shaving (implements provided)		1. Minor help, but can do about half unaided	
		2. Independent (including buttons, zips, laces, etc.)	
Toilet use		Stairs	
0. Dependent		0. Unable	
1. Needs some help, but can do something alone		1. Needs help (verbal, physical, carrying aid)	
2. Independent (on and off, dressing, wiping)		2. Independent up and down	
		Bathing	
Feeding		0. Dependent	
0. Unable		1. Independent (as in showers)	
1. Needs help cutting, spreading butter, etc.			
2. Independent (food provided within reach)			
		Total score	

Scoring:

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

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

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



Appendix B

GLOBIAD

Ghent Global IAD Categorisation Tool

THE GHENT GLOBAL IAD CATEGORISATION TOOL

Version 1.0 June



PREFACE

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

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

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

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

Kind regards

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Category 1: Persistent redness

1A - Persistent redness without clinical signs of infection



Critical criterion

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

Additional criteria

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

1A

1B - Persistent redness with clinical signs of infection



Critical criteria

- Persistent redness
A variety of tones of redness may be present. Patients with darker skin tones, the skin may be paler or darker than normal, or purple in colour.
- Signs of infection
Such as white scaling of the skin (suggesting a fungal infection) or satellite lesions (pustules surrounding the lesion, suggesting a Candida albicans fungal infection).

Additional criteria

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

1B

Category 2: Skin loss

2A - Skin loss without clinical signs of infection



Critical criterion

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

Additional criteria

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

2A

2B - Skin loss with clinical signs of infection



Critical criteria

- Skin loss
Skin loss may present as skin erosion (may result from damaged/eroded vesicles or bullae), denudation or excoriation. The skin damage pattern may be diffuse.
- Signs of infection
Such as white scaling of the skin (suggesting a fungal infection) or satellite lesions (pustules surrounding the lesion, suggesting a Candida albicans fungal infection), slough visible in the wound bed (yellow/brown/greyish), green appearance within the wound bed (suggesting a bacterial infection with Pseudomonas aeruginosa), excessive exudate levels, purulent exudate (pus) or a shiny appearance of the wound bed.

Additional criteria

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

2B

CATEGORY 1: PERSISTENT REDNESS

Category 1A: Persistent redness without clinical signs of infection

Critical criterion

Persistent redness

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

Additional criteria

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



Category 1B: Persistent redness with clinical signs of infection

Critical criteria

Persistent redness

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

Signs of infection

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

Additional criteria

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



CATEGORY 2: SKIN LOSS

Category 2A: Skin loss without clinical signs of infection

Critical criterion

Skin loss

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

Additional criteria

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



Category 2B: Skin loss with clinical signs of infection

Critical criteria

Skin loss

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

Signs of infection

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

Additional criteria

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



GLOSSARY

Bulla	A circumscribed lesion > 1 cm in diameter that contains liquid (clear, serous or haemorrhagic), a large blister
Erosion	Loss of either a portion of or the entire epidermis
Excoriation	A loss of the epidermis and a portion of the dermis due to scratching or an exogenous injury
Maceration	An appearance or surface softening due to constant wetting - frequently white
Papule	An elevated, solid, palpable lesion that is ≤ 1 cm in diameter
Pustule	A circumscribed lesion that contains pus
Scale	A visible accumulation of keratin, forming a flat plate or flake
Swelling	Enlargement due to accumulation of oedema or fluid, including blood
Vesicle	A circumscribed lesion ≤ 1 cm in diameter that contains liquid (clear, serous or haemorrhagic), a small blister

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Quality of Care Experience Aged Care Consumers

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

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

Version 2.0

November 2022

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

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Introduction

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

What is the QCE-ACC?

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

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

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



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

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

How was the QCE-ACC developed?

The QCE-ACC instrument was developed from an extensive review of Australian and international literature to identify salient aspects of the aged care experience most important for older people. This review resulted in the identification of six key quality of care experience dimensions from which



suitable questions were developed and piloted with older people. The QCE-ACC was then validated in two studies undertaken with over 1500 older people and family carers received aged care services in the community and in residential aged care. The QCE-ACC has a summary scoring system (see 'how to score the QCE-ACC' for more information).

How can the QCE-ACC be used?

Scope

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

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

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

Accessing the QCE-ACC

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

The intellectual property rights contained within the QCE-ACC materials and tools are owned by Flinders University and have been licensed to the Department of Health and Aged Care.

Versions of the QCE-ACC

Several versions of the QCE-ACC are available including:

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



Scoring the QCE-ACC

The QCE-ACC should be scored as follows:

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

Date or interview / /

1. I am treated with respect and dignity: ☐ Always ☐ Mostly ☐ Sometimes ☐ Rarely ☐ Never	4. I receive services and supports for daily living that are important for my health and wellbeing: ☐ Always ☐ Mostly ☐ Sometimes ☐ Rarely ☐ Never
2. I am supported to make my own decisions about the care and services I receive: ☐ Always ☐ Mostly ☐ Sometimes ☐ Rarely ☐ Never	5. I am supported to maintain my social relationships and connections with the community: ☐ Always ☐ Mostly ☐ Sometimes ☐ Rarely ☐ Never
3. I receive care and support from aged care staff who have the appropriate skills and training: ☐ Always ☐ Mostly ☐ Sometimes ☐ Rarely ☐ Never	6. I am comfortable lodging complaints with confidence that the appropriate action will be taken: ☐ Always ☐ Mostly ☐ Sometimes ☐ Rarely ☐ Never

Perceived quality of care experience levels are scored as:

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

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

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

Organising QCE-ACC Data

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

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

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

Preference based scoring algorithm

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

QCE-ACC Publications

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

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

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

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

Client Name or ID: _____

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Quality of Care Experience Aged Care Consumers

Self-Complete Version

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

Date of Completion ____/____/____

1. I am treated with respect and dignity:

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

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

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

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

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

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

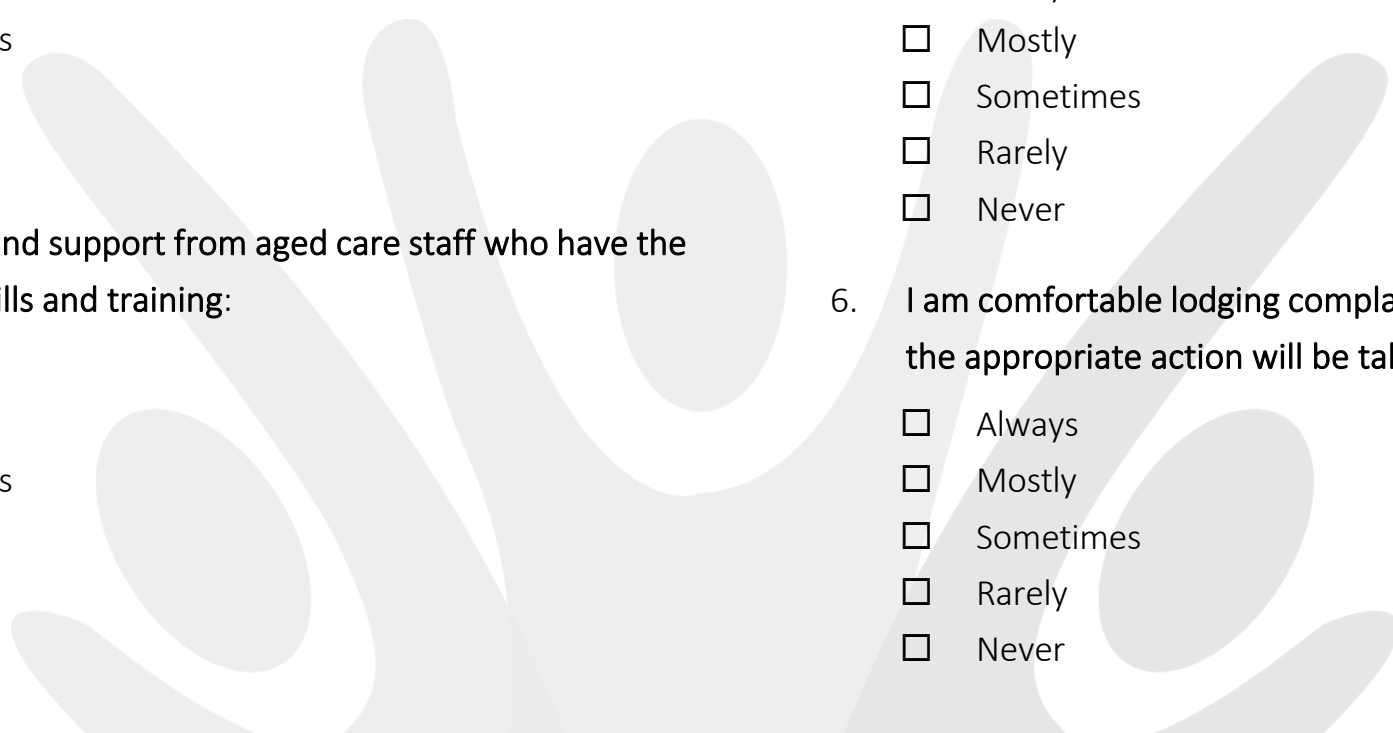
- ☐ Always
- ☐ Mostly
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

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

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

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

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





Quality of Care Experience Aged Care Consumers

Interviewer Facilitated Version

Introduction

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

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

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

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

Organisation use only

Client Name or ID: _____

Date of interview ____/____/____

1. Respect and dignity

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

The statement is:

I am treated with respect and dignity

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

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

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

(Repeat statement and response options if needed.)

2. Making my own decisions

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

The statement is:

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

The response options are:

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

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

(Repeat statement and response options if needed)

3. Trained aged care staff

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

The statement is:

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

The response options are:

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

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

(Repeat statement and response options if needed.)

4. Impact of services on health and wellbeing

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

The statement is:

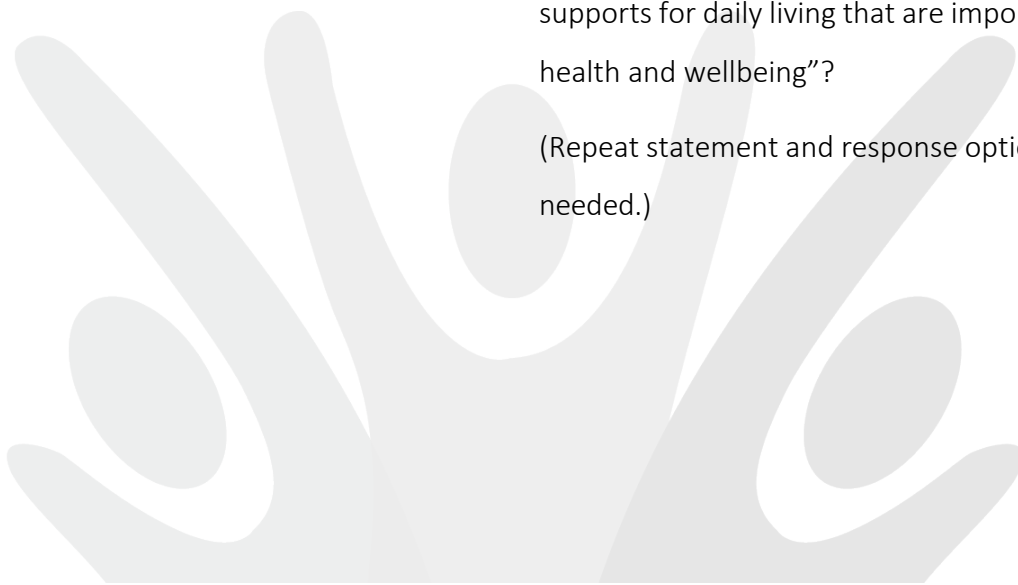
I receive services and supports for daily living that are important for my health and wellbeing

The options are:

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

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

(Repeat statement and response options if needed.)



5. Social connections

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

The statement is:

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

The options are:

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

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

(Repeat statement and response options if needed.)

6. Lodging complaints

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

The statement is:

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

The options are:

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

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

(Repeat statement and response options if needed.)



Closing

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

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

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Client Name or ID: _____

Optional

Relationship of proxy to the interviewee:

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

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Quality of Care Experience Aged Care Consumers

Proxy Version

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

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

Date of completion ____/____/____

1. I am treated with respect and dignity:

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

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

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

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

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

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

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

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

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

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

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



Quality of Life Aged Care Consumers

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

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

Version 2.0
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Suggested citation:

Hutchinson C, Ratcliffe J, Cleland J, Walker R, Milte R (2021) *QOL-ACC User Guide: Basic information on how to use the QOL-ACC instrument*, Caring Futures Institute, Flinders University, Adelaide, South Australia.

Funding acknowledgement:

This instrument was developed from a research study led by the Caring Futures Institute, Flinders University, in collaboration with researchers from the University of Sydney and Australian National University (ANU) and partner organisations ECH, Helping Hand, Uniting AgeWell, Uniting ACT NSW, Presbyterian Aged Care and Dementia Alliance International. The study was supported by funding provided by the Australian Research Council Linkage Grant scheme and partner organisations (grant no. LP170100664). The contents of the published materials are solely the responsibility of the Administering Institution, Flinders University, and the individual authors identified, and do not necessarily reflect the views of the Australian Research Council or the Funding Partners.

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Introduction

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

What is the QOL-ACC?

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



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

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

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

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

How was the QOL-ACC developed?

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



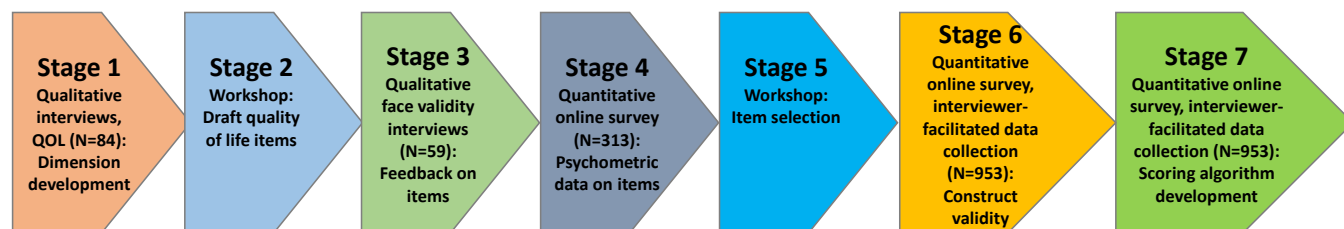
This stage identified six key quality of life dimensions: mobility, pain management, emotional well-being, independence, social connections, and activities.

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

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

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

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



How can the QOL-ACC be used?

Scope

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

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

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

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

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

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

Accessing the QOL-ACC

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

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Versions of the QOL-ACC

Several versions of the QOL-ACC are available including:

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



Scoring the QOL-ACC

The QOL-ACC should be scored as follows:

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

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

☐ All of the time

☐ Most of the time

☐ Some of the time

☐ A little of the time

☐ None of the time

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

☐ All of the time

☐ Most of the time

☐ Some of the time

☐ A little of the time

☐ None of the time

3. I am generally happy:

☐ All of the time

☐ Most of the time

☐ Some of the time

☐ A little of the time

☐ None of the time

Date of interview ____/____/____

4. I have as much independence as I want:

☐ All of the time

☐ Most of the time

☐ Some of the time

☐ A little of the time

☐ None of the time

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

☐ All of the time

☐ Most of the time

☐ Some of the time

☐ A little of the time

☐ None of the time

6. I have leisure activities/ hobbies I enjoy:

☐ All of the time

☐ Most of the time

☐ Some of the time

☐ A little of the time

☐ None of the time

Quality of life level responses are scored as:

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

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

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

Organising QOL-ACC Data

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

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

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

Preference based scoring algorithm

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

QOL-ACC Publications

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

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

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

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

Client Name or ID: _____

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Quality of Life Aged Care Consumers

Self-Complete Version

Version 2.0
November 2022

Flinders.edu.au

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

1. **I am able to get around as much as I want to** (with the use of mobility aids e.g. wheelchair, walker, stick if you use them):
- ☐ All of the time
 - ☐ Most of the time
 - ☐ Some of the time
 - ☐ A little of the time
 - ☐ None of the time
2. **When I experience pain, it is well managed:**
- ☐ All of the time
 - ☐ Most of the time
 - ☐ Some of the time
 - ☐ A little of the time
 - ☐ None of the time
3. **I am generally happy:**
- ☐ All of the time
 - ☐ Most of the time
 - ☐ Some of the time
 - ☐ A little of the time
 - ☐ None of the time

Date of completion ____/____/____

4. **I have as much independence as I want:**
- ☐ All of the time
 - ☐ Most of the time
 - ☐ Some of the time
 - ☐ A little of the time
 - ☐ None of the time
5. **I have good social relationships with family and friends:**
- ☐ All of the time
 - ☐ Most of the time
 - ☐ Some of the time
 - ☐ A little of the time
 - ☐ None of the time
6. **I have leisure activities/ hobbies I enjoy:**
- ☐ All of the time
 - ☐ Most of the time
 - ☐ Some of the time
 - ☐ A little of the time
 - ☐ None of the time



Quality of Life Aged Care Consumers

Interviewer Facilitated Version

Introduction

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

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

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

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

Organisation use only

Client Name or ID: _____

Date of interview ____/____/____

1. Mobility

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

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

The mobility statement is:

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

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

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

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

(Repeat statement and response options if needed.)

2. Pain management

The next statement is about pain management. This relates to your experience of pain and whether you feel it is well managed.

Managing pain can include the provision of heat packs, medication, or other treatments from a doctor, physiotherapist or other health care professional.

The statement is:

When I experience pain, it is well managed.

The response options are:

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

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

(Repeat statement and response options if needed.)

3. Emotional wellbeing

The third question is about emotional wellbeing.

Emotional wellbeing is about living your life without sadness, worry or stress. It is about whether you are generally happy and contented with your life.

The statement for emotional wellbeing is:

I am generally happy.

The response options are:

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

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

(Repeat statement and response options if needed.)

4. Independence

The next question is about independence.

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

The independence statement is:

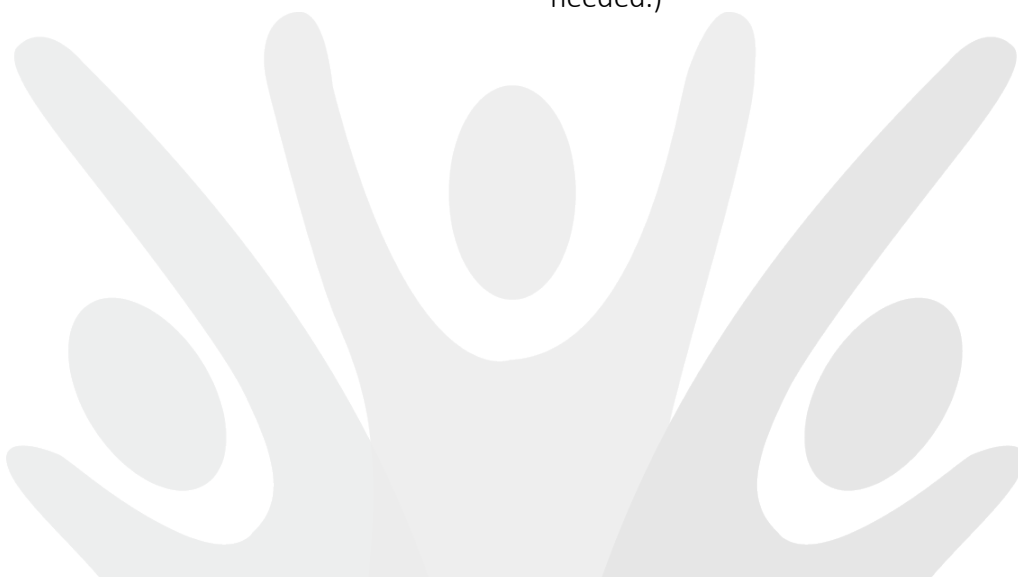
I have as much independence as I want.

The options are:

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

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

(Repeat statement and response options if needed.)



5. Social connections

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

The statement for social connections is:

I have good social relationships with family and friends.

The options are:

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

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

(Repeat statement and response options if needed.)

6. Activities

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

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

The statement for activities is:

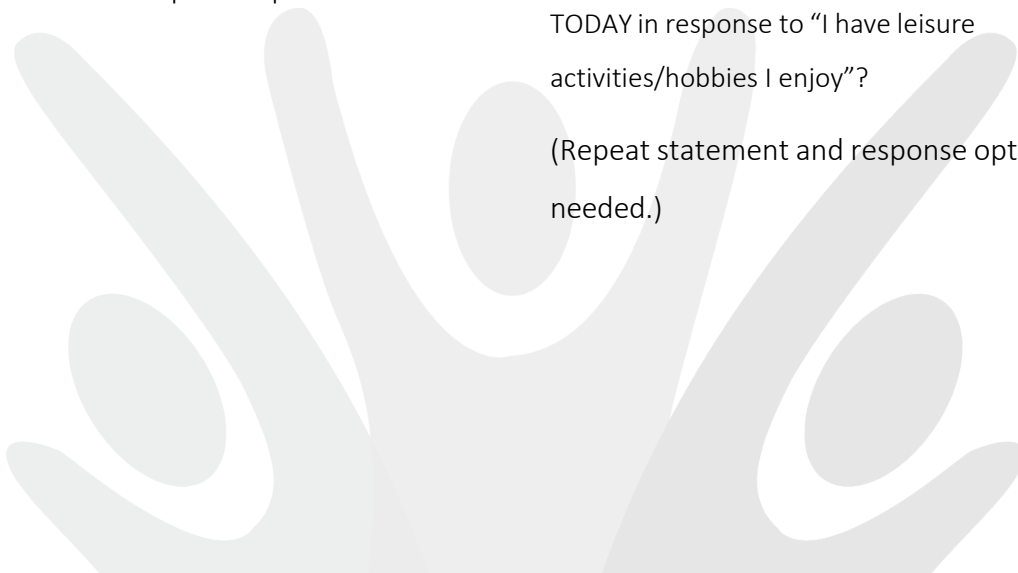
I have leisure activities / hobbies I enjoy.

The options are:

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

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

(Repeat statement and response options if needed.)



Closing

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

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Version 2.0
November 2022



Client Name or ID: _____

Optional

Relationship of proxy to the interviewee:

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

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Quality of Life Aged Care Consumers

Proxy Version

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

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

Date of completion ____/____/____

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

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

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

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

3. **I am generally happy:**

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

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

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

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

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

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

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

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