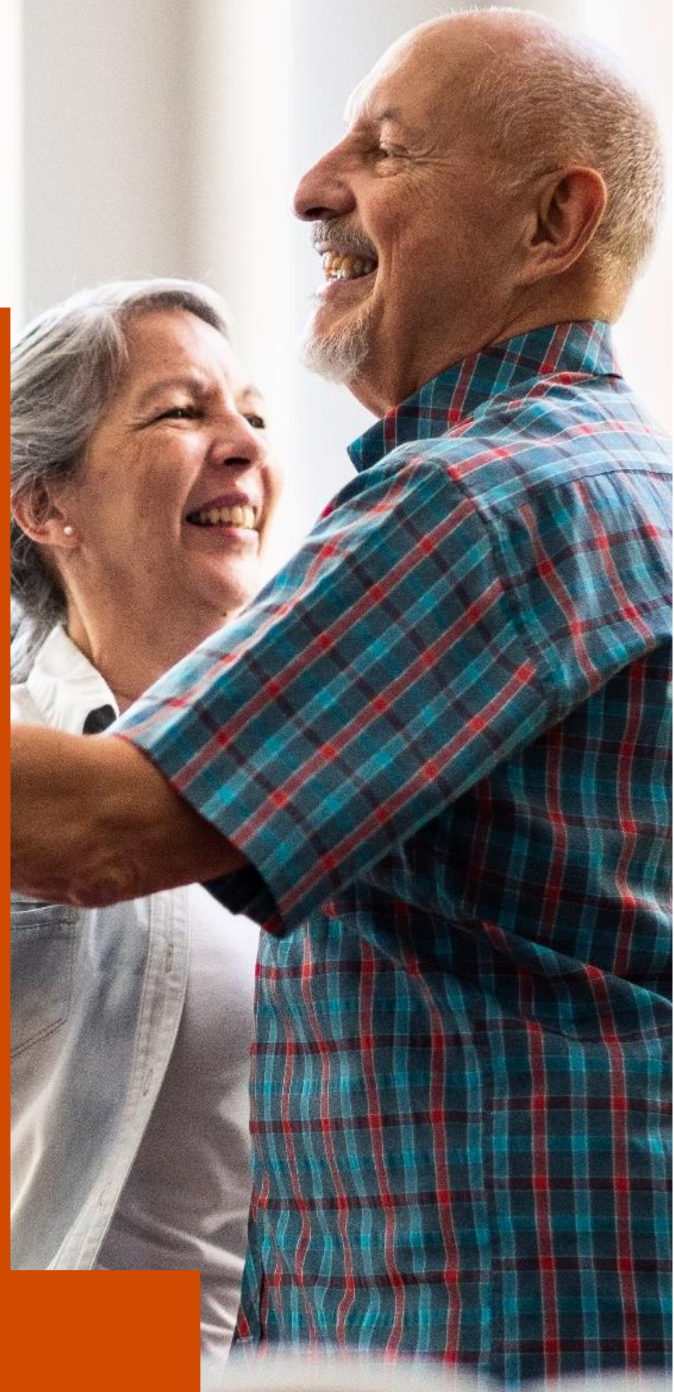
www.pwc.com



Expansion of the residential aged care quality indicators

Consultation paper

November 2021

Disclaimer

This consultation paper is not intended to be used by anyone other than Department of Health.

We prepared this consultation paper solely for Department of Health's use and benefit in accordance with and for the purpose set out in the Work Order with Department of Health dated 23 September 2021. In doing so, we acted exclusively for Department of Health and considered no-one else's interests.

We accept no responsibility, duty or liability:

- to anyone other than Department of Health in connection with this consultation paper
- to Department of Health for the consequences of using or relying on it for a purpose other than that referred to above.

We make no representation concerning the appropriateness of this consultation paper for anyone other than Department of Health. If anyone other than Department of Health chooses to use or rely on it they do so at their own risk.

This disclaimer applies:

- to the maximum extent permitted by law and, without limitation, to liability arising in negligence or under statute; and
- even if we consent to anyone other than Department of Health receiving or using this consultation paper.

Liability limited by a scheme approved under Professional Standards legislation.

Contents

Disclaimer	i
Consultation overview	3
Domain 1: Function and activities of daily living (ADLs)	5
Domain 2: Medications	8
Domain 3: Continence	10
Domain 4: Infection control	12
Domain 5: Depression	15
Domain 6: Behavioural Symptoms	17
Domain 7: Hospitalisations	19
Domain 8: Pain	21
Consumer experience and quality of life	23

Consultation overview

Executive summary

A consortium consisting of PricewaterhouseCoopers (PwC), the Centre for Health Services Research at the University of Queensland (UQ CHSR) and the Registry of Senior Australians (ROSA) at the South Australian Health and Medical Research Institute (SAHMRI) has been engaged by the Australian Government Department of Health (the Department) to assist in the development of new quality indicators for residential aged care. The project, to develop new quality indicators, is intended to guide the further expansion of the National Aged Care Mandatory Quality Indicator Program (QI Program).

The overall aims of the QI Program are to:

- provide older people with more information about the quality of aged care services when making choices about their care
- support aged care services to measure, monitor, compare and improve the quality of their services
- provide the government with system-level measures of quality in aged care and an evidence-base to inform policy and regulation.

This project commenced in September 2021; the consortium has been engaged to identify, assess, and pilot evidence-based quality indicators across four quality of care domains for residential aged care, and examine the use of assessment tools for a consumer experience and quality of life (CEQOL) domain.

A review of national and international literature identified evidence-based quality of care domains and quality indicators for possible expansion of the QI Program in residential aged care was conducted by the consortium. The domains and quality indicators were assessed and ranked in the evidence review, with those most strongly supported by the outcomes of the evidence review presented in this consultation paper. In parallel, a comprehensive evidence review of validated tools to measure quality of life, consumer experience and consumer satisfaction in aged care was conducted by Flinders University.[1] This paper also presents the CEQOL domains and assessment tools for consultation.

Purpose of consultation

The Department is are seeking feedback from aged care stakeholders to inform the quality of care domains and quality indicators selected for pilot in early 2022. This consultation paper will support online written consultations and virtual workshops to be held between 15 November – 10 December 2021.

This consultation paper has been developed to seek stakeholder feedback and views on quality of care domains for residential aged care with a particular focus on those most strongly supported by the outcomes of the evidence review:

- Domain 1: Function and Activities of Daily Living (ADLs)
- Domain 2: Medication related (not already included in QI Program)
- Domain 3: Continence
- Domain 4: Infection control (including antibiotics and vaccinations)
- Domain 5: Depression
- Domain 6: Behavioural symptoms
- Domain 7: Hospitalisations

---

[1] Ratcliffe J, Khadka J, Crocker M, Lay K, Caughey G, Cleland J, Gordon S, Westbrook J. Measurement tools for assessing quality of life, consumer satisfaction and consumer experience across residential and in-home aged care: Summary Report. Caring Futures institute, Flinders University, October 2021.

- Domain 8: Pain
- Domain 9: Service delivery and care plans
- Domain 10: Wait times.

This consultation paper also presents an overview of the assessment tools identified for the CEQOL domains.

The details of the quality of care domains and quality indicators presented in this consultation paper have been kept concise to support the consultation process. However, additional details can be found in the evidence review summary report which can be viewed at the following address. Consultation questions have been included in each section of this paper to focus the reader's attention to specific areas for consideration. The questions are not intended to be prescriptive or limit feedback. It is recognised that not all domains and questions may be applicable to the reader and therefore there is no expectation to consider all questions.

In general, the type of feedback being sought includes, but is not limited to:

- Which quality of care domains and quality indicators are most useful for quality improvement?
- Which quality of care domains and quality indicators are most appropriate for quarterly collection as part of the QI Program?
- Which CEQOL domain is most meaningful for consumer, providers, and the broader aged care sector?
- Which quality of care and CEQOL domains best meet the objectives of the QI Program?

Structure of consultation paper

This consultation paper is structured by the quality of care domains listed above. The final chapter presents the CEQOL domain.

Each chapter includes:

- an overview of the quality of care domain
- the quality indicators or assessment tools identified through the evidence review
- a summary of the key considerations for the domain and quality indicators or assessment tools
- a list of consultation questions.

The quality indicators within each domain are grouped into categories. Each quality indicator has a unique name to differentiate quality indicators that are very similar.

While reading this consultation paper, please note the terms 'clients', 'consumers' and 'patients' are used interchangeably to align with the terminology used in the country or jurisdiction the domains and quality indicators were sourced from.

If you require additional support with this consultation paper or consultation process, please contact the project team at QIpilotresidentialcare@au.pwc.com or 02 8266 1017.

Domain 1: Function and activities of daily living (ADLs)

Overview of domain

Activities of daily living (ADLs) are categorised as basic and instrumental (IADLS). Basic ADLs include the fundamental skills required to manage basic physical needs such as personal hygiene, dressing, toileting/continence, transferring or ambulating, and eating. IADLS are more complex tasks such as managing finances, preparing meals and managing transportation. High and medium needs to conduct activities of daily living (ADL) are reported by over 80 per cent of people living in residential aged care.[2] ADLs are essentially a measurement of independence. Measuring independence in ADLs is important as a decline often correlates with a decline in health, potentially resulting in poor health outcomes and care issues (e.g. hospitalisation, pressure injuries, pneumonia, constipation) and a lower quality of life. Residents who are less independent also require additional care.

Quality indicators for this domain

ID	Quality indicators
A	**Residents with improvement in function and/or ADLs**
A.1	Residents who had improvement of function in some basic ADLs
A.2	Residents who improved in their ability to locomote
A.3	Residents who improved or remained independent in mid-loss ADLs
A.4	Residents who improve in mid-loss ADL functioning, or remain completely independent in mid-loss ADLs
A.5	Residents who improved or remained independent in early-loss ADLs (data published annually)
A.6	Residents who improve in early-loss ADL functioning or remain completely independent in early-loss ADLs
A.7	Residents who improved or remained independent in early-loss ADLs (data published annually with previous four years)
B	**Residents with worsened function and/or ADLs**
B.1	Residents who declined in their ability to locomote
B.2	Residents who experienced a decline in independence of locomotion
B.3	Residents who worsened or remained dependent in early-loss ADLs (published annually with quarterly data)
B.4	Residents whose need for help with late-loss ADLs has increased
B.5	Residents who worsened or remained dependent in early-loss ADLs (published annually with data for the past four years)
B.6	Residents who worsened or remained dependent in mid-loss ADLs
B.7	Residents who have declined in ADLs

[2] Australian Government. Australian Institute of Health and Welfare. People's care needs in aged care. (https://www.gen-agedcaredata.gov.au/Topics/Care-needs-in-aged-care).

ID	Quality indicators
B.8	Residents who declined in mid-loss ADL functioning or remain completely dependent in mid-loss ADLs
B.9	Residents who had unexpected loss of function in some basic ADLs
B.10	Residents who declined in early-loss ADL functioning or remain completely dependent in early-loss ADLs
B.11	Residents who decline in late-loss ADLs (incidence)
B.12	Residents who decline in range of motion (incidence)
C	**Residents with lack of nursing care to support independence with ADLs**
C.1	Residents with lack of nursing rehabilitation in late-loss ADLs
D	**Residents with little or no activity**
D.1	Residents with little or no activity (data collected 6-monthly)
D.2	Residents with little or no activity (data collected quarterly)
E	**Residents who are bedfast (unable to leave bed)**
E.1	Residents who are bedfast (in a 6-month period)
E.2	Residents who are bedfast (in a 4-month period)

Key considerations

There are several considerations for these quality indicators:

- Varied definitions for ADLs are used and advice is sought on the most suitable definition for the Australian context.
- Several quality indicators within this domain focus on similar ADL concepts, but measure either an improvement or decline in ADLs. There is an opportunity to advise on whether there is a preference to measure improvement or decline in ADLs.
- The QI Program currently uses prevalence measures to identify the proportion of care recipients at one time within a service who meet the quality indicator definition (i.e. percentage of care recipients who experienced one or more falls). Many of the quality indicators use incidence measures, requiring sequential assessments of residents to monitor their change in condition over time.
- Some of the quality indicators require the use of validated or standardised tools to assess ADLs. Licenses to use these tools may be required.
- How quality indicators within this domain should be reported across residential aged care services providing different levels of care. Noting, aged care services providing high level care are likely to report a higher number of residents who are bedfast or have little activity. By comparison, aged care services supporting low level care are likely to have fewer residents who are bedfast or have little activity.

Consultation questions

1. Does quarterly measuring/monitoring of function and ADLs support quality improvement for residential aged care services?
2. Are there contemporary tools used in aged care in Australia to measure function and ADLs?
3. Can residential aged care services influence function and ADLs?
4. How feasible would it be for residential aged care services to collect and report quarterly on this data?
5. Is it more useful to measure point in time (point prevalence) or improvement/decline over time for people?
6. What function and ADLs are most important to measure (specific ADLS, mobilisation, early-loss of ADLs)?
7. In measuring ADLs, is there a preference to measure improvement, maintenance or decline in function?
8. Could quarterly reporting on function and ADL quality indicators help consumers to choose services?

Domain 2: Medications

Overview of domain

Australia declared medicine safety as its tenth national health priority area in 2019 with medications being some of the most common medical interventions. With the increasing prevalence of multimorbidity and associated polypharmacy (the prescription of nine or more medications) in the growing older population, older people's medication related needs have become increasingly complex. Polypharmacy is associated with an increased risk of adverse events and poor health outcomes. The QI Program in Australia currently includes a medication management domain which includes quality indicators relating to antipsychotic medications and polypharmacy. However, the evidence review identified several additional medication sub-domains including sedative load, inappropriate medication use and medication reviews.

Quality indicators for this domain

ID	Quality indicators
A	**Residents receiving antianxiety or hypnotic sedatives**
A.1	Residents potentially experiencing a high sedative load
A.2	Residents who received an antianxiety or hypnotic medication (data collected quarterly)
A.3	Residents who received an antianxiety or hypnotic medication but do not have evidence of psychotic or related conditions
A.4	Residents who received an antianxiety or hypnotic medication (data collected six-monthly)
A.5	Residents who received an antianxiety or hypnotic medication (in the last 7 days)
A.6	Residents who received hypnotic medications three or more times (in the last 7 days)
A.7	Residents who received two or more hypnotic medications (in the last 7 days)

Key considerations

There are several considerations for these quality indicators:

- There are existing quality indicators for medication management as part of the QI program (focused on use of antipsychotic medications and polypharmacy). If additional quality indicators were piloted from this domain, it may inhibit selecting a more holistic suite of quality indictors where measures compliment or offset each other (i.e. falls and restraint).
- Many of the quality indicators within this domain rely on the use of the residential aged care service's medical records. While this may be straightforward for services using electronic medication records, this may be a burden for services that use a paper-based medication record system.
- The QI Program currently uses prevalence measures to identify the proportion of care recipients at one time within a service who meet the quality indicator definition (i.e. percentage of care recipients who experienced one or more falls). Many of the quality indicators use incidence measures, requiring sequential assessments of residents to monitor their change in condition over time.
- Guidance information on Australian-specific medication names and types to classify antianxiety, hypnotic, or sedatives may be required.
- How quality indicators within this domain should be reported across residential aged care services providing different levels of care. Noting, aged care services providing high level care are likely to report a higher number of residents who prescribed such medications.

- The use of sedatives may be strongly influenced by the resident profile, particularly psychogeriatric and dementia specific facilities / programs, which will benefit from risk adjustment as part of program maturation more broadly.

Consultation questions

1. Does quarterly measuring/monitoring of antianxiety or sedative use support quality improvement for residential aged care services?
2. Can residential aged care services influence the results of medication quality indicators?
3. How feasible would it be for residential aged care services to collect and report quarterly on this data?
4. Given the existing antipsychotic medication and polypharmacy quality indicators, would quality indicators focused on antianxiety or sedative use be beneficial?
5. Given the existing medication management domain within the QI program, would it be beneficial to extend the domain with an additional quality indictor or would it be more beneficial to measure a new quality of care domains?
6. Could reporting on medication quality indicators help consumers make decisions about choosing services?

Domain 3: Continence

Overview of domain

Continence is the ability to control one's bladder and bowel elimination, and incontinence is the involuntary loss of bladder and bowel control. Incontinence is not a physiological part of the ageing process and can often be successfully treated. Age-related changes together with frailty, cognitive decline, or impaired mobility, can put older adults at risk of incontinence. Incontinence is an important consideration as having bowel and bladder control can prevent other poor health outcomes (e.g. infection, pressure injuries). Furthermore, when residents receive treatment for incontinence it can improve their well-being (both dignity and assisting them socially). With the right treatment and assistance from health care professionals and service providers, continence can improve.

Quality indicators for this domain

ID	Quality indicators
A	**Residents with worsened incontinence**
A.1	Residents with worsened bladder continence
A.2	Residents with worsening bladder continence
A.3	Residents with worsening bowel continence
B	**Residents with incontinence**
B.1	Residents with bladder or bowel incontinence (data collected quarterly)
B.2	Residents with bladder or bowel incontinence (data collected 6-monthly)
B.3	Residents who frequently lose control of their bowel or bladder
C	**Residents with improving continence**
C.1	Residents with improving bladder continence
C.2	Residents with improving bowel continence
D	**Residents with incontinence who do not have a toileting plan**
D.1	Residents with frequent bladder or bowel incontinence without a toileting plan
D.2	Residents with occasional or frequent bladder or bowel incontinence without a toileting plan
E	**Residents with in-dwelling catheters**
E.1	Residents with in-dwelling catheters (data published quarterly)
E.2	Residents with in-dwelling catheters
E.3	Residents with in-dwelling catheters (data published 6-monthly)
E.4	Residents with in-dwelling catheters (in the past 7 days)
E.5	Residents with in-dwelling catheters (in the past 3 days)

ID	Quality indicators
F	**Residents with faecal impaction**
F.1	Residents with faecal impaction (data collected 6-monthly)
F.2	Residents with faecal impaction (data published quarterly)

Key considerations

There are several considerations for these quality indicators:

- Several quality indicators within this domain focus on similar concepts in continence, but measure either improvement or decline in continence. There is an opportunity to advise on whether there is a preference to measure improvement or decline in continence. Is it more useful to measure point in time (point prevalence) or improvement/decline over time for people?
- The quality indicators cover a range of different concepts associated with continence. It is necessary to determine whether quality indicators should reflect multiple aspects of continence (bladder and bowel) or only one aspect (bladder or bowel).
- The QI Program currently uses prevalence measures to identify the proportion of care recipients at one time within a service who meet the quality indicator definition (i.e. percentage of care recipients who experienced one or more falls). Many of the quality indicators use incidence measures, requiring sequential assessments of residents to monitor their change in condition over time.

Consultation questions

1. Does quarterly measuring/monitoring continence support quality improvement in residential aged care services?
2. Are there contemporary tools used in aged care in Australia to measure continence?
3. How feasible would it be for residential aged care services to collect and report quarterly on this data?
4. What are the most important continence quality indicators to measure (bladder, bowel, catheters, or all)?
5. Is it more important to measure improvement, maintenance or decline in continence? Is it more useful to measure point in time continence (point prevalence) or improvement/decline over time for people?
6. Are there process indicators[3] (i.e., continence *management*) that would be appropriate as quality indicators?
7. Could quarterly reporting on continence quality indicators help consumers make decisions about choosing services?

[3] Process indicators measure activities or systems within a service. For example, for continence, a process indicator would assess the management plan for continence management.

Domain 4: Infection control

Overview of domain

Infections are a significant cause of mortality and morbidity in older people. Older people, especially people living in residential aged care services are at high risk of infection and sepsis, partially due to age-related factors such as pathological changes to the immune system, malnutrition, incontinence, functional disability, impaired cognitive status, and presence of chronic diseases. Older people may not display typical symptoms making early detection of infection challenging. Urinary tract infections (UTIs) are an infection of any part of the urinary tract, with bladder infections being most common. Some UTIs can be prevented through good hygiene, toileting processes and hydration.

Quality indicators for this domain

ID	Quality indicators
A	**Residents and staff receiving influenza vaccinations**
A.1	Staff who received the most recent influenza vaccine
A.2	Residents who received the most recent influenza vaccine (data collected annually)
A.3	Residents who received the most recent influenza vaccine (data collected quarterly)
A.4	Residents who were assessed and/or appropriately given the most recent influenza vaccine
B	**Residents with systemic antibiotic or at least one antimicrobial prescription**
B.1	Residents dispensed at least one antibiotic for systemic use
B.2	Residents prescribed at least one antimicrobial (on the collection day)
C	**Residents receiving the pneumococcal vaccination**
C.1	Residents who have received the pneumococcal vaccination
C.2	Residents who received the pneumococcal vaccination (in the last 12 months)
C.3	Residents whose pneumococcal vaccine status is up to date
D	**Residents receiving treatment for specific, or multiple infections**
D.1	Residents who had signs and/or symptoms of at least one suspected infection (on the collection day)
D.2	Residents who have had one or more infections
D.3	Residents who have had a Methicillin-resistant Staphylococcus aureus infection
D.4	Residents who have had a Clostridium difficile infection
D.5	Residents who have had a Vancomycin-resistant Enterococcus infection
E	**Residents receiving the herpes zoster vaccination**
E.1	Residents who receive the herpes zoster vaccination
F	**Residents declining or unable to receive the influenza vaccinations**
F.1	Residents who are offered and decline the most recent influenza vaccination

ID	Quality indicators
F.2	Residents who did not receive the influenza vaccine due to medical contraindication
G	Residents declining or unable to receive pneumococcal vaccinations
G.1	Residents who are offered and decline the pneumococcal vaccine
G.2	Residents who did not receive the pneumococcal vaccine due to medical contraindication
H	Residents with a urinary tract infection
H.1	Residents who have had one or more urinary tract infections
H.2	Residents with a urinary tract infection
H.3	Residents who have had a urinary tract infection (in the last 30 days) (data collected quarterly)
H.4	Residents who have had a urinary tract infection (in the last 30 days)

Key considerations

There are several considerations for these quality indicators:

- Attribution for various quality indicators may be difficult to determine. With quality indicators potentially influenced by various care providers, including health care providers (i.e. antibiotic prescribing) and the residential aged care service. It will be necessary to consider which quality indicators are within the direct influence of a residential aged care service.
- It is acknowledged that there is legislation in place related to staff vaccination and therefore consideration should be given as to whether inclusion of a quality indicator related to this is necessary.
- Consideration should be given as to the importance of aspects of infection control such as antibiotics, antimicrobials and urinary tract infections versus the measurement of vaccination rates.
- Data collection for most quality indicators relies on the use of resident's medication records. While this may be straightforward for services using electronic medication records, this may be a burden for services that use a paper-based medication record system.
- Several quality indicators focus on specific vaccinations (influenza, herpes zoster or pneumococcal). It is necessary to consider the value of measuring a single specific vaccination.
- Guidance information on Australian-specific medication names and types to classify medications (i.e. antimicrobials or antibiotics) may be required.

Consultation questions

1. Does quarterly measuring/monitoring infection control or vaccination support quality improvement in residential aged care services?
2. Can residential aged care services influence these quality indicators?
3. How feasible would it be for residential aged care services to collect and report quarterly on this data?
4. What is more important to measure in relation to infection control; antibiotics, antimicrobials and urinary tract infections versus the measurement of vaccination rates?
5. Which of antibiotics, antimicrobials and urinary tract infections are more important to measure?
6. What are most important vaccination quality indicators to measure (influenza, pneumococcal, herpes zoster etc)?
7. Could quarterly reporting on infection control or vaccination quarterly help consumers make decisions about choosing services?

Domain 5: Depression

Overview of domain

Depression is a common and serious mood disorder that can affect all aspects of an individual's life. Individuals who suffer depression may experience persistent feeling of sadness and hopelessness and lose interest in activities they normally would enjoy. An estimated half of all people living in residential aged care have depression. Depression symptoms such as fatigue, loss of interests, low mood and concentration problems can be managed, improved, or resolved through behavioural or pharmacological therapies.[4] Aged care services are expected to detect and provide support to address changes and deterioration of mental, cognitive, or physical function, capacity, or condition of consumers. Identifying depression in residents can be complicated by individual circumstances (e.g. loss of a spouse, chronic pain and illness, major life changes in moving to residential care and/or cognitive decline). Depression can negatively impact people's quality of life.

Quality indicators for this domain

ID	Quality indicators
A	**Residents with worsening depression or declining mood**
A.1	Long term care residents whose symptoms of depression worsened (data published quarterly)
A.2	Long term care residents whose symptoms of depression worsened (rolling four quarter average)
A.3	Residents whose symptoms of depression worsened
A.4	Residents with mood decline and symptoms of depression (over the last seven days)
A.5	Residents who have declined in their mood from symptoms of depression
B	**Residents with symptoms of depression**
B.1	Residents who have had symptoms of depression (in the last two weeks)
B.2	Residents with a Depression Rating Scale score of three or more
C	**Residents with declining mood or other symptoms of depression not receiving anti-depressants**
C.1	Residents with a Depression Rating Scale score of three or more and not receiving an antidepressant
C.2	Residents with mood decline and symptoms of depression and not receiving an antidepressant (over the last seven days)

[4] Alexopoulos GS. Depression in the elderly. The Lancet 2005;365(9475):1961-1970.

Key considerations

There are several considerations for these quality indicators:

- Varied definitions for depression, mood or depressive systems are used and advice is sought on the most suitable definition for the Australian context.
- Several quality indicators within this domain focus on similar concepts in depression, but measure either an improvement or a decline in depression, mood or depressive symptoms. There is an opportunity to advise on whether there is a preference to measure improvement, decline or both in depression, mood or depressive symptoms. Is it more useful to measure point in time (point prevalence) or improvement/decline over time for people?
- The QI Program currently uses prevalence measures to identify the proportion of care recipients at one time within a service who meet the quality indicator definition (i.e. percentage of care recipients who experienced one or more falls). Many of the quality indicators use incidence measures, requiring sequential assessments of residents to monitor their change in condition over time.
- Many of the quality indicators require the use of validated or standardised tools to assess depression. Licenses to use these tools may be required. If alternative, but similar quality indicators were to be developed for the pilot, a process of selection, implementation of measures and assessment requirements would be required. It may be preferable for residents to self-complete assessments, or the use of a proxy may be required (i.e. family member, carer, or both). Consideration is needed to determine when and how a proxy should be used to complete the assessment.

Consultation questions

1. Does quarterly measuring/monitoring depression, mood or depressive symptoms support quality improvement in residential aged care services?
2. Are there contemporary tools used in aged care in Australia to measure depression, mood or depressive symptoms?
3. Can residential aged care services influence a resident's symptoms of depression, mood or depressive symptoms?
4. How feasible would it be for residential aged care services to collect and report quarterly on this data?
5. What depression quality indicators are the most important to measure (all moods, depression symptoms, diagnosed depression)?
6. Is it more important to measure improvement, decline or prevalence in depression, mood or depressive symptoms?
7. Could quarterly reporting on depression, mood or depression quality indicators help consumers make decisions about choosing services?

Domain 6: Behavioural Symptoms

Overview of domain

Behaviour and personality changes are often part of the progression of dementia. These symptoms can often include moodiness, anxiety, apathy, agitation, irritability sleeping problems, wandering and confusion. Dementia is often associated with behavioural and psychosocial symptoms of dementia (BPSD). BPSD symptoms are often managed with pharmacological treatment and can contribute to the over-reliance on antipsychotics in older people living in residential aged care.

Quality indicators for this domain

ID	Quality indicators
A	**Residents with worsened behavioural symptoms**
A.1	Residents with worsened behavioural symptoms (data published quarterly)
A.2	Residents with worsened behavioural symptoms (data published quarterly by levels of care)
B	**Residents with improved behavioural symptoms**
B.1	Residents with improved behavioural symptoms (data published quarterly by levels of care)
B.2	Residents with improved behavioural symptoms (data published quarterly)
C	**Residents who have behavioural symptoms that affect others**
C.1	Residents who display inappropriate behaviour that affect others
C.2	Residents who have behavioural symptoms that affect others (data published six-monthly)
C.3	Residents who have behavioural symptoms that affect others (data published quarterly)
D	**Resident whose ability to communicate has worsened**
D.4	Residents whose ability to communicate has worsened
E	**Resident whose ability to communicate has improved**
E.5	Residents whose ability to communicate has improved

Key considerations

There are several considerations for these quality indicators:

- Varied definitions, assessment tools and screening processes for behavioural symptoms are used and advice is sought on the most useful for the Australian context.
- Several quality indicators within this domain focus on similar concepts in behavioural symptoms, but measure either improvement or decline in problematic behaviour. There is an opportunity to advise on whether there is a preference to measure improvement or decline in behavioural symptoms. Is it more useful to measure point in time (point prevalence) or improvement/decline over time for people?
- The QI Program currently uses prevalence measures to identify the proportion of care recipients at one time within a service who meet the quality indicator definition (i.e. percentage of care recipients who experienced one or more falls). Many of the quality indicators use incidence measures, requiring sequential assessments of residents to monitor their change in condition over time.

- Many of the quality indicators require the use of validated or standardised tools to assess behavioural symptoms. Licenses to use these tools may be required. If alternative, but similar quality indicators were to be developed for the pilot, a process of selection, implementation of measures and assessment requirements would be required. It may be preferable for residents to self-complete assessments, or the use of a proxy may be required (i.e. family member, carer, or both). Consideration is needed to determine when and how a proxy should be used to complete the assessment.
- Including quality indicators in the pilot that are related to behavioural symptoms should be considered in light of the existing quality indicators within the QI Program and any unanticipated changes in practice that may occur. For example, there may be pressure for services between reducing inappropriate use of antipsychotic medications without a diagnosis of psychosis (a current quality indicator) which may result in increased problematic behaviour (possibly a new quality indicator).
- Despite recent improvements to normalise mental health conditions, including depression, these conditions continue to attract significant stigma. Consideration needs to be given to how this stigma is considered within a service if screening all residents for depression.

Consultation questions

1. Does quarterly measuring/monitoring behavioural symptoms support quality improvement in residential aged care services?
2. Are there contemporary tools used in aged care in Australia to measure behavioural symptoms?
3. Can residential aged care services influence a resident's behavioural symptoms?
4. How feasible would it be for residential aged care services to collect and report quarterly on this data?
5. What behaviour is most important to measure (all behavioural symptoms or only behavioural symptoms impacting others)?
6. Is it more important to measure improvement, maintenance, or decline in behavioural problems in residents? Is it more useful to measure point in time behaviour (point prevalence) or improvement/decline over time for people?
7. Are specialised workers (e.g. registered nurses or psychologists) needed to collect data for these quality indicators?
8. Could quarterly reporting on behavioural quality indicators help consumers make decisions about choosing services?

Domain 7: Hospitalisations

Overview of domain

Hospitalisations are admissions to hospitals to receive treatment, which can be planned (i.e. elective) or unplanned. Emergency department care is also provided in many hospitals, and this includes urgent care provision that may or may not result in hospital admission. In 2018 – 19, 37 per cent of people living in Australian residential aged care services had at least one hospitalisation and 37 per cent at least one emergency department (ED) presentation.[5] Common reasons for hospitalisations in people living in residential aged care services are falls, respiratory related conditions, and acute infections. Many hospitalisations are considered potentially preventable with preventative health interventions, early disease management, or potential better access to certain care within the residential aged care service.

Quality indicators for this domain

ID	Quality indicators
A	**Emergency Department presentation or hospitalisation for medication-related events**
A.1	Emergency Department presentation or hospitalisation for medication-related events
B	**Emergency Department visits that did not result in outpatient or inpatient hospitalisation or hospice enrolment**
B.1	Emergency Department visits that did not result in outpatient or inpatient hospitalisation or hospice enrolment
C	**Unplanned inpatient hospital admissions or outpatient observation stays while not enrolled in hospice**
C.1	Unplanned inpatient hospital admissions or outpatient observation stays while not enrolled in hospice
D	**Residents who had an Emergency Department presentation or were hospitalised for delirium or dementia**
D.1	Residents who had an Emergency Department presentation or were hospitalised for delirium or dementia
E	**Emergency Department presentation within 30 days of discharge from hospital**
E.1	Emergency Department presentation within 30 days of discharge from hospital

Key considerations

There are several considerations for these quality indicators:

- How quality indicators within this domain should be reported across residential aged care services providing different levels of care. Noting, aged care services providing high level care are likely to report a higher number of residents who are admitted to hospital or visit an Emergency Department. By comparison, aged care services supporting low level care are likely to have fewer residents who are admitted to hospital or visit an Emergency Department.
- Most quality indicators use non-provider self-reported data regarding hospital admissions. This approach is not suitable given the pilot will collect primary data directly from residential aged care services.
- Quality indicators within this domain measure various aspects, such as Emergency Department of hospitalisation events, or the cause of hospitalisation (i.e. medication related or delirium/dementia). It is necessary to determine which aspects of the domain are most important. Emergency presentations may reflect existing risk protocols within residential care to seek Emergency Department care in certain circumstances to manage risk (e.g. in the event of a fall

[5] Commonwealth of Australia. Royal Commission into Aged Care Quality and Safety. Research Paper 18: Hospitalisations in Australian Aged Care: 2014/15-2018/19.

in a resident who is taking blood thinning medications). In the Australian aged care context, admissions may be more appropriate for measuring/monitoring for quality improvement or to inform consumer choice.

Consultation questions

1. Does quarterly measuring/monitoring hospitalisation or hospital presentation support quality improvement in residential aged care services?
2. Can residential aged care services influence hospitalisation or hospital presentation?
3. How feasible would it be for residential aged care services to collect and report quarterly on this data?
4. Do services currently collect or review data on hospitalisation or hospital presentation of residents?
5. Is there types of hospitalisation or hospital presentation that are more important to measure (unplanned admission, inpatient admission)?
6. Are factors associated with the cause of hospitalisation or hospital presentation that are important to measure for residential aged care services (i.e. delirium, dementia)?
7. Could quarterly reporting on hospitalisation or hospital presentation quality indicators help consumers make decisions about choosing services?

Domain 8: Pain

Overview of domain

The 2020 International Association for the Study of Pain definition of pain is "an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage."[6] Pain affects a significant and increasing portion of older adults receiving aged care services.[7] Pain affects people's functional capabilities, activities of daily living, quality of life, and overall disability. The pharmacological management of pain is common in older people, but older people are also more susceptible to the potential complications and side effects associated with pain medications, such as non-steroidal anti-inflammatory drugs (NSAIDs) and opioids. Adverse events include functional impairment, falls, respiratory depression, constipation, dependency from opioids as well as associated renal, gastrointestinal, and cardiovascular effects from NSAIDs.

Quality indicators for this domain

ID	Quality indicators
A	**Residents whose pain worsened**
A.1	Residents whose pain worsened (data published annually)
A.2	Residents whose pain worsened (data published quarterly)
A.3	Residents whose pain worsened (data published quarterly by levels of care)
B	**Residents who had moderate daily pain or horrible/excruciating pain**
B.1	Residents who had moderate daily pain or horrible/excruciating pain (data published annually)
B.2	Residents who had moderate daily pain or horrible/excruciating pain (data published quarterly)
C	**Residents with daily pain (over last three days)**
C.1	Residents with daily pain (over last three days)
D	**Residents that are chronic opioid users**
D.1	Residents that are chronic opioid users
E	**Residents with daily moderate or higher pain or residents with non-daily very strong pain**
E.1	Residents who experienced moderate pain daily or any severe pain (over the last 7 days)
E.2	Residents with daily moderate or higher pain or residents with non-daily very strong pain (over the last seven days) (self-reported)
E.3	Residents with daily moderate or higher pain or residents with non-daily very strong pain (over the last seven days) (observed)

[6] Abdulla A, Adams N, Bone M, et al. Guidance on the management of pain in older people. Age Ageing 2013;42 Suppl 1:i1-57. DOI: 10.1093/ageing/afs200.

[7] Inacio MC, Visvanathan R, Lang C, et al. Pain in Older Australians Seeking Aged Care Services: Findings from the Registry of Older South Australians (ROSA). JAMDA 2020;21(1):132-133.

Key considerations

There are several considerations for these quality indicators:

- Varied definitions and measurement tools for pain are used and advice is sought on the most useful for the Australian context.
- Several quality indicators within this domain focus on similar concepts in pain, but measure either improvement or decline in pain. There is an opportunity to advise on whether there is a preference to measure improvement or decline in pain.
- The QI Program currently uses prevalence measures to identify the proportion of care recipients at one time within a service who meet the quality indicator definition (i.e. percentage of care recipients who experienced one or more falls). Many of the quality indicators use incidence measures, requiring sequential assessments of residents to monitor their change in condition over time.
- Many of the quality indicators require the use of validated or standardised tools to assess pain. Licenses to use these tools may be required. If alternative, but similar quality indicators were to be developed for the pilot, a process of selection, implementation of measures and assessment requirements would be required. It may be preferable for residents to self-complete assessments, or the use of a proxy may be required (i.e. family member, carer, or both). Consideration is needed to determine when and how a proxy should be used to complete the assessment.
- How quality indicators within this domain should be reported across residential aged care services providing different levels of care. Noting, aged care services providing high level care are likely to report a higher number of residents who experience high levels of pain. By comparison, aged care services supporting low level care are likely to have fewer residents who experience high levels of pain.

Consultation questions

1. Does quarterly measuring/monitoring pain support quality improvement in residential aged care services?
2. Are there contemporary tools used in aged care in Australia to measure pain?
3. Can residential aged care services influence pain in residents?
4. How feasible would it be for residential aged care services to collect and report quarterly on this data?
5. What pain quality indicators are most important to measure (change in pain, severe pain, daily pain)?
6. Is it more important to measure existence or frequency or severity of pain?
7. Could quarterly reporting on pain quality indicators help consumers make decisions about choosing services?

Consumer experience and quality of life

To capture the voices of aged care consumers an assessment tool measuring quality of life, consumer experience or consumer satisfaction will be implemented.

Quality of life refers to a consumer's perception of their position in life taking into consideration their contextual environment and their goals, expectations, standards, and concerns.[8] It includes their emotional, physical, material, and social wellbeing.

Consumer experience looks at the experience of the consumer receiving care. This Consumer Experience Reports developed by the Aged Care Quality and Safety Commission currently capture aspects of consumer experience.[9]

Consumer satisfaction is a measurement that determines how well a service is meeting the consumers expectations, it also assesses the level of a consumer's fulfillment with the care and services provided to them.

The associated assessment tools will allow consumers to provide feedback on their lived experience, and, over time, provide information on quality in aged care to assist consumer decision making. In addition, the assessment tool will support residential aged care services with access to robust, valid data to monitor performance and ensure continuous quality improvement.

The tools to measure quality of life, consumer experience or consumer satisfaction are not inter-changeable as they measure different concepts or dimensions (i.e. wellbeing, social relationships, independence).

The Royal Commission into Aged Care Quality and Safety recommended a quality of life assessment tool should be implemented in residential and in-home aged care. [10] A review of quality of life, consumer experience and consumer satisfaction assessment tools by Flinders University identified quality of life as the most important measure for aged care. [11]

Assessment tools for this domain

#	Assessment tool
A	**Quality of life**
A.1	**Quality of Life–Aged Care Consumers (QOL-ACC)** This tool has been designed specifically for quality assessment in aged care to capture consumer (older person and family carer) focused quality of life outcomes from their own perspective. It was codesigned with consumers in Australia for used in aged care. The tool consists of six dimensions: mobility, emotional wellbeing, social connections, independence, activities, and pain management with five response levels attached to each dimension. There are self-completed, interviewer administered and proxy versions of the QOL-ACC available.

8 World Health Organization (2012). The World Health Organization Quality of Life (WHOQOL).

9 Aged Care Quality and Safety Commission. A voice and choice in quality care. Consumer Experience Reports: Residential Aged Care Services.

10 Royal Commission into Aged Care Quality and Safety, Commonwealth of Australia. Final report 2021.

11 Ratcliffe J, Khadka J, Crocker M, Lay K, Caughey G, Cleland J, Gordon S, Westbrook J. Measurement tools for assessing quality of life, consumer satisfaction and consumer experience across residential and in-home aged care: Summary Report. Caring Futures institute, Flinders University, October 2021.

#	Assessment tool
A.2	**Good Spirit, Good life tool (GSGL)** This non-preference based tool measures the quality of life of older Aboriginal Australians aged 45 years and over. It consists of twelve dimensions: family and friends, country, community, culture, health, respect, elder role, supports and services, safety and security, spirituality, future planning, and basic needs. There is also a carer version of the tool available. It is the first instrument of its kind developed from its inception with older Aboriginal people and was designed to be applied with this population.
A.3	**Dementia Quality of Life tool (DEMQOL)** This non-preference based tool measures the health-related quality of life of individuals with dementia. The tool has five dimensions: health and well-being, cognitive functioning, social relationships, daily activities, and self-concept. There are 28 self-report measures completed by the person with dementia, and 31 items competed by a caregiver.
B	**Consumer experience**
B.1	**Quality of Care-Aged Care Consumers (QCE-ACC)** The QCE-ACC is a preference-based measure of aged care specific quality of care experience. It has six dimensions: respect and dignity, services and supports, decision-making, staff skills and training, social relationships, and feedback.
B.2	**Consumer Choice Index – 6 Dimensions (CCI-6D)** The CCI-6D is preference based tool used to evaluate the quality of care in long term care facilities from the perspective of the consumer. The CCI-6D contains six questions, each of which focus on a quality of care dimension identified by older people with cognitive decline as being important to their quality of care (care time; spaces; own room; outside and gardens; meaningful activities and care flexibility). There are three levels of response for each question.
B.3	**Consumer Experience Questionnaire (CEQ)** The CEQ is a non-preference based tool that captures consumers' experience of care. The tool covers ten dimensions of care which are important to the consumer's experience of care: dignity, autonomy, and choice; assessment and planning; care; lifestyle; service; feedback; human relations; governance; food; and independence. There are twelve questions in the tool. Ten of the questions are dedicated to capturing the consumer's experience of care relevant to one of the dimensions. The final two questions are open-ended and ask the resident for general comments about the best aspect of their care and general feedback to improve their experience of care.
C	**Consumer satisfaction**
C.1	**Resident Satisfaction Questionnaire (RSQ)** The RSQ was developed in 1998 in Australia to measure aged care residents' level of satisfaction with their care. It covers ten dimensions (50 questions): overall level of satisfaction; care by staff; individual needs; your room; residential centre; social life and involvement in the aged care centre; links with the community; chaplaincy services; resident services; resident involvement and feedback.
C.2	**Consumer Perception of Value Questionnaire (CPVQ)** The CPVQ captures residential aged care residents' level of satisfaction with the care and services provided to them. There are two versions of the tool – one that captures the level of satisfaction with care from the resident's perspective (64 questions), and one that captures the level of satisfaction with care from the family member's perspective (67 questions). Both versions of the CPVQ cover nine 9 dimensions: welcome; delivery of care; spiritual life; meals; cleanliness; laundry; activities; facilities; and overall satisfaction.

Key considerations

There are several considerations for these assessment tools:

- There are currently no recommendations on how often quality of life, consumer experience or consumer satisfaction assessments should be completed. Consideration should be given to the appropriate frequency of assessment tool administration.
- It is preferable for consumers to self-complete quality of life, consumer experience and consumer satisfaction assessments, using a proxy (i.e. family member, carer, or both) only when required. Consideration should be given to when and how a proxy should be used to complete the assessment.
- Assessment tools are available in different formats, including via tablet, computer or hard copy (pen and paper survey). Consideration is required to understand consumer preferences and the resources needed within residential aged care services when administering the preferred assessment.
- Assessment comprehensiveness varies across the three domains, and consideration should be given to whether quality of life, being a holistic approach and particularly suited to the residential aged care environment (i.e. services have direct control over the consumers health and wellbeing), would be most suited to pilot.
- Consumer experience tools (e.g. QCE-ACC and CCI-6D) have proven acceptable to the sector being easy to complete, collecting what is considered to be ‘meaningful’ information and resulting in high response rates, consideration should be given whether this is the most feasible domain for implementation.
- The consumer satisfaction tools have wide applicability to consumers and services. However, evidence from the broader health system suggests that consumer satisfaction tools may not be a reliable measure of quality due to the presence of ‘satisfaction bias’. Consumer satisfaction is often overwhelmingly positive and unequal to true levels of satisfaction. This may in turn, impact the variation of the results across services, reducing its value as a measure to support quality improvement and, in time, consumer choice. The presence of this bias will need to be considered in the implementation of consumer satisfaction tools.

Consultation questions

1. Does quarterly measuring/monitoring these concepts support quality improvement in residential aged care services?
2. Are there preferred tools for the measurement of quality of life, consumer experience or consumer satisfaction?
3. Can residential aged care services influence quality of life in residents?
4. Can residential aged care services influence consumer experience in residents?
5. Can residential aged care services influence consumer satisfaction in residents?
6. How feasible would it be for residential aged care services to collect and report quarterly on this data?
7. Is it more important to measure quality of life, consumer experience, or consumer satisfaction?
8. Could quarterly reporting on quality of life, consumer experience or consumer satisfaction quality indicators help consumers make decisions about choosing services?

www.pwc.com.au

© 2021 PricewaterhouseCoopers Consulting (Australia) Pty Limited. All rights reserved. PwC refers to PricewaterhouseCoopers Consulting (Australia) Pty Limited, and may sometimes refer to the PwC network. Each member firm is a separate legal entity. Please see www.pwc.com/structure for further details. Liability limited by a scheme approved under Professional Standards Legislation.
127084565