



Australian Government
Department of Health



myagedcare



National Aged Care Quality Indicator Programme

Resource manual for residential aged care facilities

January 2016 edition

PART B: Appendices – resources and additional information

This is an extract of the original resource manual and can be used as a separate resource

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Do you need assistance?

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

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

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Appendix 1 – Quality Indicators

Quality Indicators (QIs) today

The information technology revolution in the last 25 years has radically changed the way we gather, analyse and share data about the provision of care in all human service settings. Healthcare, aged care, disability care and childcare services are all now expected to collect and report on performance data, and implement improvement measures as a result.

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

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

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

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

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

Attributes of QIs

The attributes of a robust QI include:

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

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

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

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

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

Comparable QIs allow risk adjustment for inter-organisational comparison.

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

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

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

Consider what happens next

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

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

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

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

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

Data integrity and validation

Importance of data integrity

Definition and collection

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

Data needs to be checked for completeness and accuracy.

Reliability has multiple elements.

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

The data sources you use must be an accurate reflection of what happens in your residential facility, and they must consistently capture the elements required for each QI. A robust QI Programme will test the reliability of data. This requires planning and completing data audits to check the information collected.

Validation

There are three methods for assessing validity:

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

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

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

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

Questions to consider include:

Is the QI associated with quality of care?

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

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

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

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

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

QIs can be used to test systems to determine how events could occur, and they play an important role in risk management.

Appendix 2 – Example template for scheduling Quality Indicator data collection

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

Facility name:			
Schedule for QI data collection			
Quarter 3 2015 – 2016, January 1 to 31 March 2016			
Quality Indicator	Advice	Date of collection	Responsibility
1. Pressure injuries	Every resident will be assessed for pressure injuries once each quarter. The assessment can be conducted either by assessing every resident over a set period of up to 14 days, or by identifying an assessment date for each resident and completing the assessment on the same day for each quarter.	Assessment period: All residents over 14 days ____ / ____ /2016 to ____ / ____ /2016 OR A date for each resident	Name: _____
2. Use of physical restraint	Every resident will be assessed by observation for use of physical restraint. There are two measures to be collected for physical restraint during each assessment. Identify three assessment days in each quarter. On each of these days, conduct three observations of each resident, one during the morning, one in the afternoon and one at night. This is a total of nine observation assessments over the quarter. Observations should be unannounced. Do not disclose the timing of the observation to staff, except for the person conducting the observation.	Assessment 1 on ____ / ____ /2016	Assessment 1: Staff member to do the morning observation (name): _____ Staff member to do the afternoon observation (name): _____ Staff member to do the night observation (name): _____
		Assessment 2 on ____ / ____ /2016	Assessment 2: Staff member to do the morning observation (name): _____ Staff member to do the afternoon observation (name): _____ Staff member to do the night observation (name): _____

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

Appendix 3 – Quality Indicator 1: Pressure injuries

Evidence to support this Quality Indicator (QI)

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

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

Defining pressure injuries

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

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

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

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

Pressure injuries in aged care

Older people are particularly vulnerable to developing pressure injuries.

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

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

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

Adverse clinical events and pressure ulcers

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

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

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

Common causes of death as a result of pressure injury development include osteomyelitis³ and septicaemia (Jaul 2010; Bates-Jensen, 2001). Osteomyelitis is an infection of the bone and may be acute or chronic (Skinner 2006).

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

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

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

Causes of pressure injuries

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

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

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

³ A pressure ulcer can provide an inlet for bacteria to enter the body and cause osteomyelitis.

Aside from the incidence of comorbidities and chronic diseases associated with older age that may contribute to pressure injury development, there are specific age-related changes to skin which also increase the risk of occurrence (Jaul 2010; Dealey 2005; and Macklebust and Sieggreen 2001).

These changes include:

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

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

Table 2: Factors contributing to pressure injury development and residential aged care

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

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

Why are these issues significant?

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

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

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

Resource list

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

Australian Wound Management Association website, which includes *Prevention and treatment of pressure ulcers: clinical practice guidelines 2014*: <www.awma.com.au>

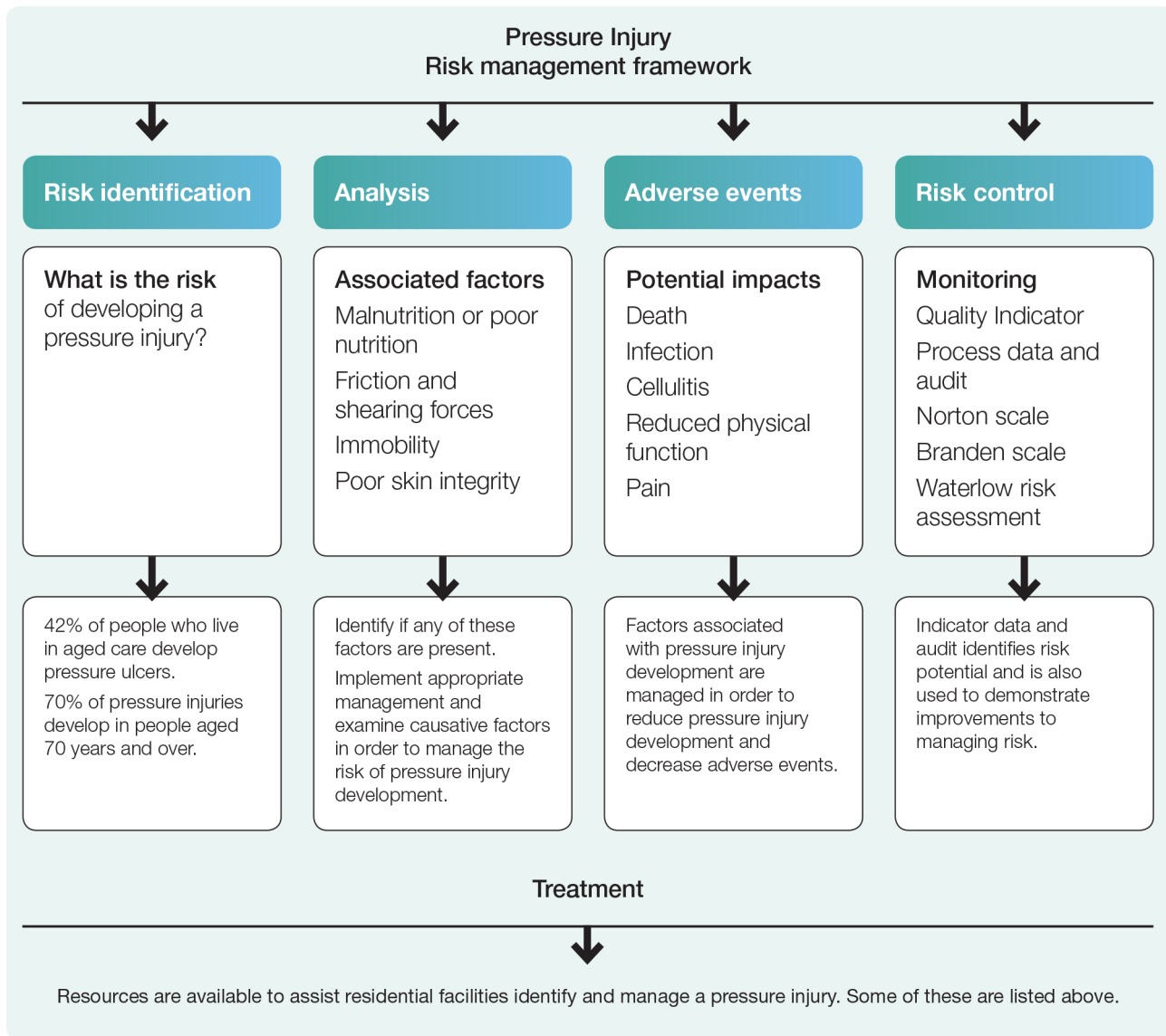
Department of Health, *Pressure ulcer basics online education program*: <www.health.vic.gov.au/pressureulcers/education.htm> (currently being updated to include stage 6 for pressure injuries)

Joanna Briggs Institute, Best Practice information sheets '*Prevention of pressure related damage*' and '*Management of Pressure related tissue damage*' available with membership.

Tools and resources developed for the National Safety and Quality Service Standards: Standard 8 Preventing and Managing Pressure Injuries, including Queensland Health 2012: <www.health.qld.gov.au/psu/safetyandquality/docs/pip-audit-def.pdf>

West Australian Government Department of Health wound education modules <www.health.wa.gov.au/WoundsWest/education>

Figure 6: Pressure injury risk management framework



Source: adapted with permission from Victorian Department of Health, 2015, *Quality Indicators in public sector residential aged care services, Resource materials, January 2015 edition*. Victorian Department of Health & Human Services, Melbourne.

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

Pressure injuries data collection sheet

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

Facility name:								
Quality Indicator 1. Pressure injuries								
Quarter 3 2015 – 2016, January 1 to 31 March 2016								
Assessment date	Resident (all residents)	Stage 1	Stage 2	Stage 3	Stage 4	Unstageable	Suspected deep tissue injuries	Comments
February 3 2016	Mrs Example code 114	0	0	1	0	0	0	This resident is new and the injury was present on admission.
February 3 2016	Mr Example code 115	1	0	0	0	0	0	This resident is receiving end of life palliative care
February 4 2016	Ms Example code 116	3	0	0	2	0	0	This resident is new and the injury was present on admission.
Total	3	4	0	1	2	0	0	3 x Stage 1; 1 x Stage 3 and 2 x Stage 4 present on admission. 1 x Stage 1 from a resident receiving end-of-life palliative care.

Pressure injuries data recording sheet

This example of a recording sheet can be adapted for use to summarise your QI data collected (table above) for Quality indicator 1: Pressure injuries. This information is a total for the facility for each quarter, which you will submit to the Australian Government Department of Health (the department) through the My Aged Care (Provider Portal).

Pressure injuries	
Name of facility	
Reporting quarter end date	Quarter 3 2015 – 2016, January 1 to 31 March 2016
Assessment completed date	
Total number of residents assessed	3
Total number of residents in the facility	3

	Stage 1	Stage 2	Stage 3	Stage 4	Unstageable	Suspected deep tissue injuries	Total injuries
Number of pressure injuries	4	0	1	2	0	0	7

Comments

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

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

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

Appendix 5 – Quality Indicator 2: Use of physical restraint

Evidence to support this Quality Indicator (QI)

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

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

Defining physical restraint

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

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

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

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

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

The significance of physical restraint in residential aged care

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

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

Rationale for the use of restraint is often embedded in the perception that it reduces risks to resident safety (and the safety of others) as a result of falls, wandering, aggression, agitation and unpredictable behaviour.

There is also evidence that suggests older people living in residential aged care are physically restrained due to inadequate staff supervision.

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

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

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

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

This example highlights the importance of understanding:

- what physical restraint is
- its appropriateness in residential aged care
- the negative outcomes associated with it.


Adverse clinical events and the use of physical restraint

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

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

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

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



However, the literature acknowledges that in some situations the use of physical restraint may be the last option available to manage a specific issue.

The psychological and physical adverse outcomes for residents caused by physical restraint can be serious. Research indicates that physical restraint clearly impacts on a resident's mental health, including their emotional wellness and social engagement.

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

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

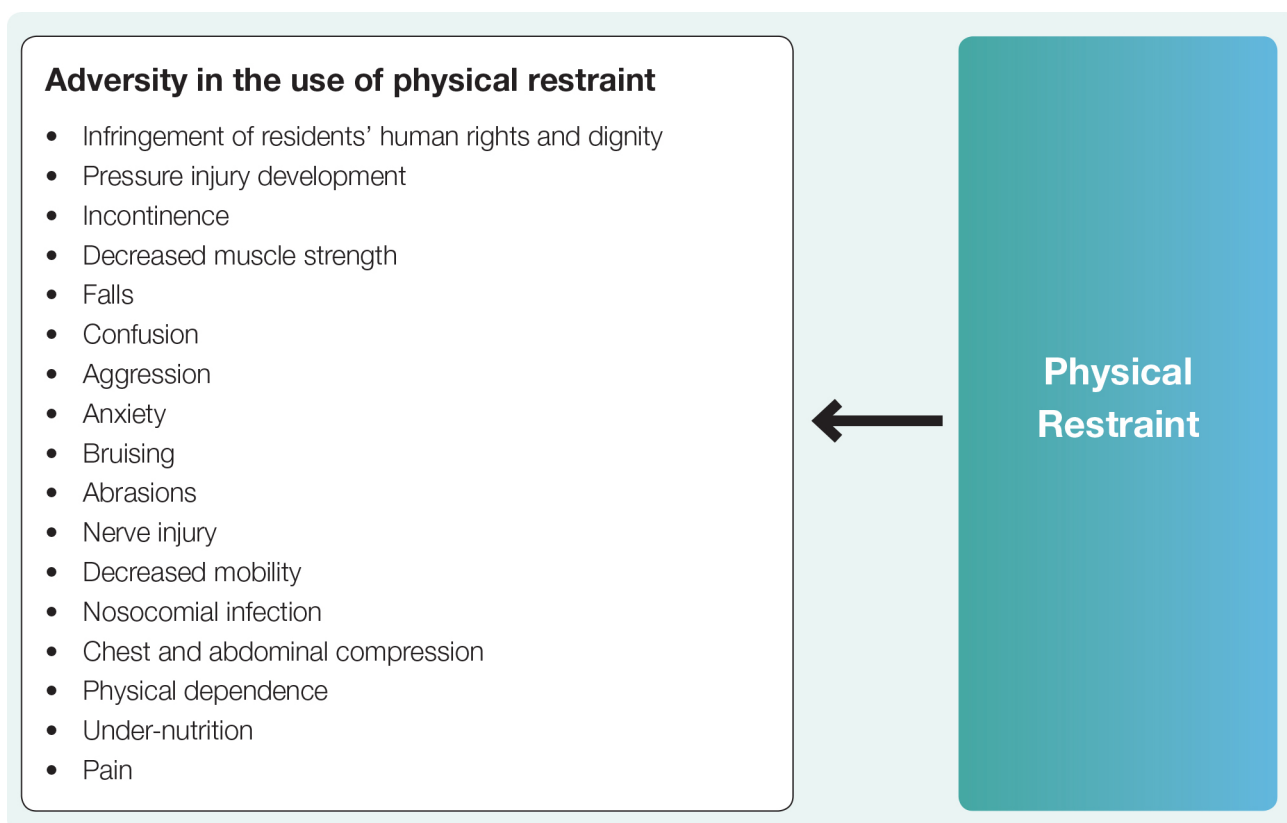
The Australian and New Zealand Society for Geriatric Medicine (2012) cites emotional desolation, withdrawal, fear and anger as consequences of physical restraint.

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

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

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

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

Figure 7: Adverse clinical events, other than mortality, associated with restraint

Source: Adapted from Feng et al. 2009, Gelkopf et al. 2009, Pellfolk et al. 2010, Knox 2007, Meyer et al. 2008, Fogel et al. 2009, Timmins 2008, Agens 2010, Lane and Harrington 2011, Evans et al. 2003, Gastmans and Milisen 2005.

Why physical restraint occurs

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

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

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

These are:

- prevention of falls
- management of aggressive/inappropriate behaviour
- prevention of injury to the confused resident

- prevention of wandering
- reducing interference with ‘treatments’ and medical devices
- risk reduction during periods of low/inadequate staff supervision.

When measured against the adverse outcomes of the use of restraint outlined above it is clear that these rationales are contradictory. In addition, the Australian and New Zealand Society for Geriatric Medicine (2012) clearly states the use of physical restraint should never be used to compensate for inadequate staffing numbers.

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

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

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

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

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

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

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

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

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

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

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

A restraint-free care environment is the recommended standard of care (Rathnayake 2012).

The evidence highlights that restraint places residents at risk of adverse events. The following resources may assist residential facilities in their prevention and management of physical restraint.

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

Resource list

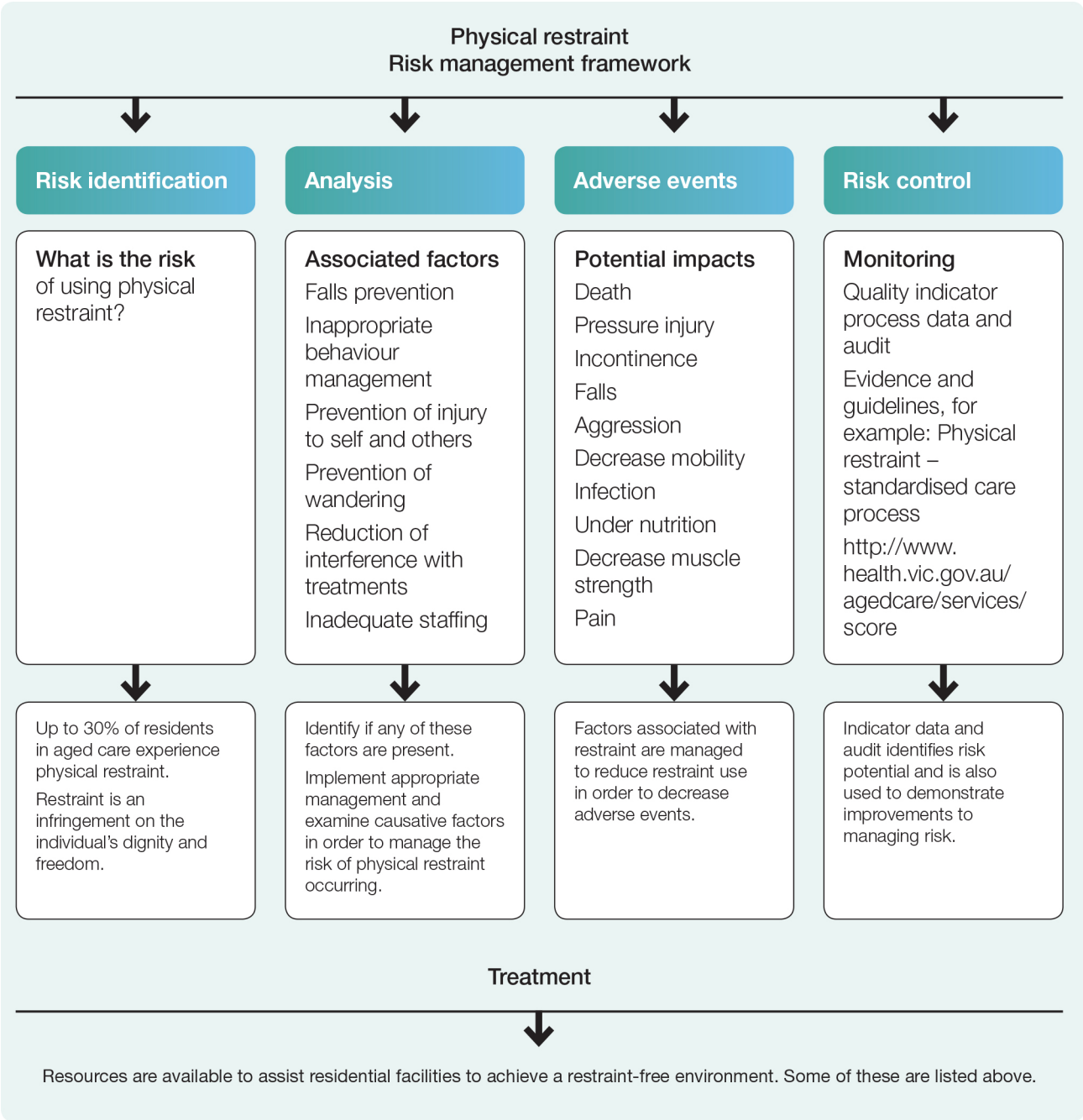
A range of resources and information is available to support residential aged care facilities to achieve a restraint free environment.

Department of Health and Ageing 2012, *Decision-making tool: supporting a restraint-free environment in residential aged care*, Commonwealth Government of Australia, Canberra <<https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/publications-articles/resources-learning-training/decision-making-tool-supporting-a-restraint-free-environment>>

Department of Health 2014, *Standardised care process (SCP): physical restraint*, State Government of Victoria, Melbourne <www.health.vic.gov.au/agedcare/downloads/score/restraint_scp.pdf>

NSW Department of Health 2006, *Guidelines for working with people with challenging behaviours in residential aged care facilities - using appropriate interventions and minimising restraint*, State Government of New South Wales, North Sydney <www.health.nsw.gov.au/policies/gl/2006/pdf/GL2006_014.pdf>

Figure 8: Physical restraint risk management framework



Source: adapted with permission from Victorian Department of Health, 2015, *Quality Indicators in public sector residential aged care services, Resource materials, January 2015 edition*. Victorian Department of Health & Human Services, Melbourne.

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

Physical restraint collection sheet

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

Facility name:				
Quality Indicator 2: Use of physical restraint				
Quarter 3 2015 – 2016, January 1 to 31 March 2016				
Assessment 1: Date __ / __ / __ Time By	Observation (morning)	Observation (afternoon)	Observation (night)	Total
Measure 1: Intent to restrain - total number of restraints.				Box 1
Measure 2: Physical restraint devices - total number of restraints				Box 2
Assessment 2: Date __ / __ / __ Time By	Observation (morning)	Observation (afternoon)	Observation (night)	Total
Measure 1: Intent to restrain - total number of restraints				Box 3
Measure 2: Physical restraint devices - total number of restraints				Box 4
Assessment 3: Date __ / __ / __ Time By	Observation (morning)	Observation (afternoon)	Observation (night)	Total
Measure 1: Intent to restrain - total number of restraints				Box 5
Measure 2: Physical restraint devices - total number of restraints				Box 6

Physical restraint data recording sheet

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

Use of physical restraint	
Name of facility	
Reporting quarter end date	Quarter 3 2015 – 2016, January 1 to 31 March 2016

Assessment date 1:		Number of residents assessed:	
Assessment date 2:		Number of residents assessed:	
Assessment date 3:		Number of residents assessed:	

	Assessment Day 1	Assessment Day 2	Assessment Day 3	Total for all 3
Measure 1: Intent to restrain	From box 1	From box 3	From box 5	Box 1 + 3 + 5
Measure 2: Physical restraint devices	From box 2	From box 4	From box 6	Box 2 + 4 + 6

Comments

Measure 1: Intent to restrain.

- **Required** if applicable – indicate the total number of residents who were intentionally restrained during any of the audits.
- **Required** if applicable – record the number of uses of restraint in the total that were specifically requested by the resident and / or their family and / or advocate. This will be the total of the three assessments, which is Box 7 + 9 + 11 from the table below.

For example, '12 restraint uses from the total were water chairs requested by family.'

Measure 2: Physical restraint devices.

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

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

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

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

Additional information in relation to the comments section

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

Facility name:				
Quality Indicator 2: Use of physical restraint				
Quarter 3 2015 – 2016, January 1 to 31 March 2016				
Assessment 1: Date __ / __ / __ Time By	Observation (morning)	Observation (afternoon)	Observation (night)	Total
Measure 1: Intent to restrain - total number of restraints requested by a resident and / or their family and / or advocate.				Box 7
Measure 2: Physical restraint devices - total number of restraints requested by a resident and / or their family and / or advocate.				Box 8
Assessment 2: Date __ / __ / __ Time By	Observation (morning)	Observation (afternoon)	Observation (night)	Total
Measure 1: Intent to restrain - total number of restraints requested by a resident and / or their family and / or advocate.				Box 9
Measure 2: Physical restraint devices - total number of restraints requested by a resident and / or their family and / or advocate.				Box 10
Assessment 3: Date __ / __ / __ Time By	Observation (morning)	Observation (afternoon)	Observation (night)	Total
Measure 1: Intent to restrain -total number of restraints requested by a resident and / or their family and / or advocate.				Box 11
Measure 2: Physical restraint devices - total number of restraints requested by a resident and / or their family and / or advocate.				Box 12

Appendix 7 – Quality Indicator 3: Unplanned weight loss

Evidence to support this Quality Indicator (QI)

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

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

Defining unplanned weight loss

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

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

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

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

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

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

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

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

The Dietitians Association of Australia (Watterson et al. 2009) has identified that measuring weight loss over time can predict malnutrition.

However, there is some variation regarding the definition of clinically significant weight loss in relation to malnutrition.

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

Severe: BMI less than 18.5 kg/m² or unintended weight loss of more than 10 per cent

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

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

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

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

Unplanned weight loss in aged care

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

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

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

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

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

Adverse clinical events and unplanned weight loss

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

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

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

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

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

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

Causes of unplanned weight loss

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

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

Pain, illness, chronic, malignant and neurological disease can all contribute to weight changes in the older person (ADA 2010; McMinn et al. 2011; SCIE 2009).

But it is the growing prevalence of dementia and its link to weight loss that raises concern. Several studies indicate that the presence of dementia is linked to unplanned weight loss.

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

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

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

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

They include factors such as:

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

Some of these behaviours are described as aversive. Gillette Guyonette et al. (2007) describe aversive feeding behaviours as:

- dyspraxia and agnosia – unable to use utensils properly or recognise food
- resistance – avoiding food, refusing to open mouth, spitting out the food, and aggression towards the person assisting them

- propharyngeal dysphagia – problems with control with mouth, tongue and swallowing
- changed behaviours and food preferences – wandering, refusal to eat requested food, altered preferences for taste or texture of food.

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

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

These changes include:

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

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

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

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

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

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

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

Staffing issues can also affect unplanned weight loss in residents, including:

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

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

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

Adjustment strategies include:

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

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



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

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

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

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

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

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

Table 3: Mnemonic MEALSONWHEELS

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

Source: Morley et al. 1995

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

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

Resource list

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

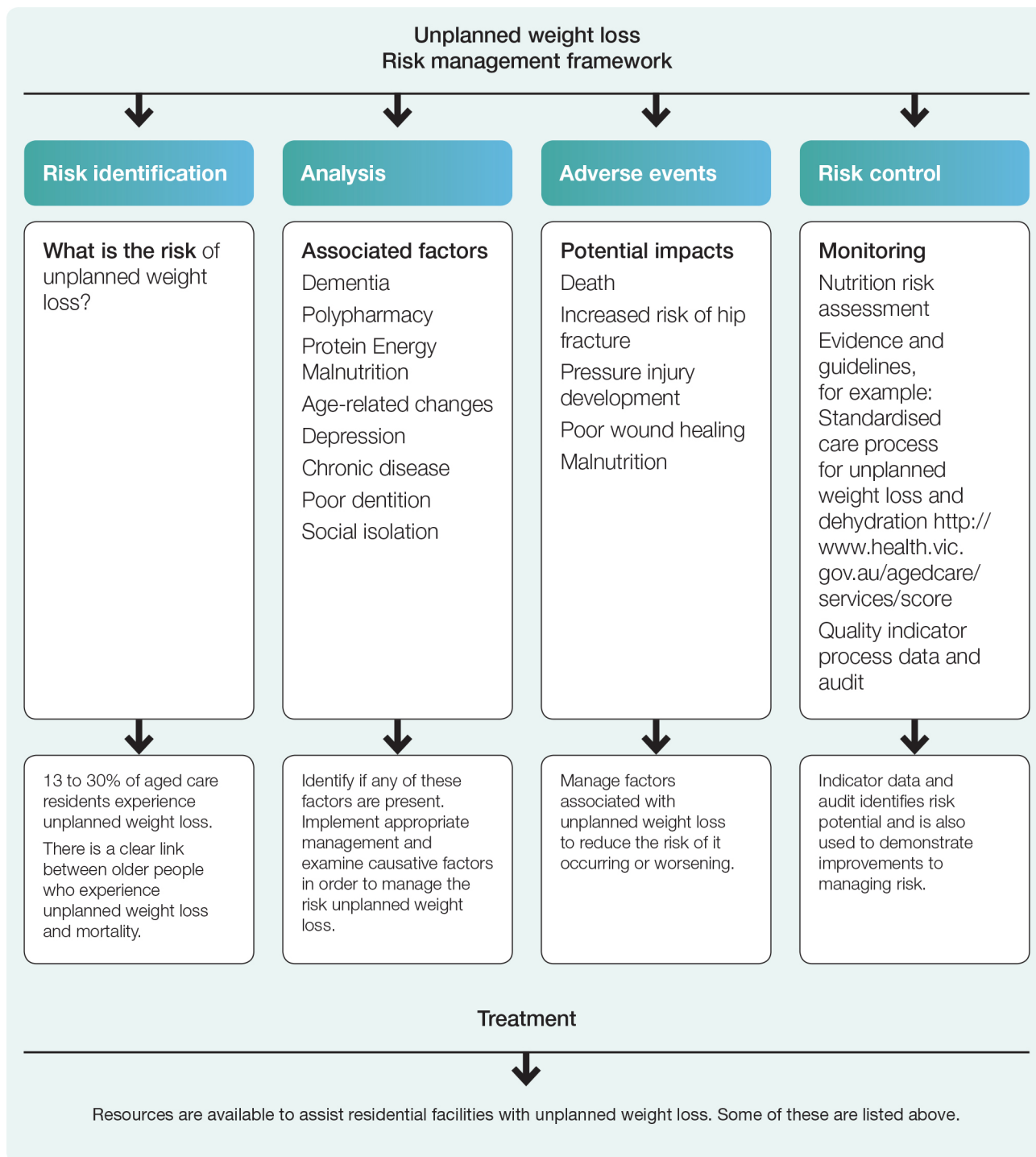
Department of Health, Standardised care process: unplanned weight loss, State Government of Victoria, Melbourne <www.health.vic.gov.au/agedcare/downloads/score/weightloss_scp.pdf>

Department of Health, Standardised care process: dehydration, State Government of Victoria, Melbourne <www.health.vic.gov.au/agedcare/downloads/score/dehydration_scp.pdf>

Department of Health, Well for life: improving nutrition and physical activity for residents of aged care facilities, State Government of Victoria, Melbourne <www.health.vic.gov.au/agedcare/maintaining/wellforlife_pubs.htm>

Dietitians Association of Australia 2009, 'Evidence-based guidelines for nutritional management of malnutrition in adult patients across the continuum of care', Nutrition & Dietetics, vol. 66, suppl. 3, S1–S34 <www.clinicalguidelines.gov.au/browse.php?treePath=&pageType=2&fldgIriD=1617&

Figure 9: Unplanned weight loss risk management framework



Source: adapted with permission from Victorian Department of Health, 2015, *Quality Indicators in public sector residential aged care services, resource materials, January 2015 edition*. Victorian Department of Health & Human Services, Melbourne.

Appendix 8 – Example template for recording data for Quality Indicator 3: Unplanned weight loss

Unplanned weight loss collection sheet

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

Facility name:											
Quality Indicator 3: Unplanned weight loss (please note that all weights are in kgs)											
Quarter 3 2015 – 2016, January 1 to 31 March 2016											
Assessment date:											
1	2	3	4	5	6	7	8	9	10	11	12
Resident	Weight carried forward from previous month	Jan	+ Or -	Feb	+ Or -	Mar	+ Or -	Total + or – for Quarter	1* Lost 3 Kg or more this quarter Y or N	2# Lost every month Y or N	Comments
Mrs Example code 114	83.5	83.7	+0.2	82.8	-0.9	80.4	-2.4	-3.1	Y	N	
Mr Example code 115	76.3	76.0	-0.3	75.5	-0.5	75.3	-0.2	-1.0	N	Y	
Ms Example code 116	80.0	80.0	-	-	-	80.5	+0.5	+0.5	N	N/A	In hospital in February and weight could not be measured, therefore not included for either measure in the total
Total										1	1

*Measure 1: Significant unplanned weight loss #Measure 2: Consecutive unplanned weight loss

Unplanned weight loss data recording sheet

This example of a recording sheet can be adapted for use to summarise your QI data collected (table above) for Quality Indicator 3: Unplanned weight loss. This information is a total for the facility for each quarter which you will submit to the Australian Government Department of Health (the department) through the My Aged Care Provider Portal (Provider Portal).

Unplanned weight loss	
Name of facility	
Reporting quarter end date	Quarter 3 2015 – 2016, January 1 to 31 March 2016
Assessment date	

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

Number of residents whose weight was monitored*	Number of residents who experienced significant unplanned weight loss
	This is the total number of 'Yes' in column 10. For this example 1.

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

Number of residents whose weight was monitored*	Number of residents who experienced consecutive unplanned weight loss
	Total number of 'Yes' in column 11. For this example 1.

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

Comments

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

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

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

Appendix 9 – Using Quality Indicator data and setting targets

Using Quality Indicator (QI) data – governance

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

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

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

- Board and executive

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

The role of the board and executive is to provide the governance, leadership and oversight for quality of care.

Their leadership role includes demonstrating a willingness to challenge the status quo and seeking objective information about performance and promoting transparency and accountability.

What may not be visible to them are the direct hands-on aspects of service delivery.

- Managers and quality personnel

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

Their role is to support the implementation and facilitate the interpretation of information relevant to service delivery. This may include active management and participation in the collection, reporting and responding to QIs.

They also implement specific interventions within the facility to improve care, such as explaining the facility's QIs to staff. The challenge is personalising QI data so it is relevant and real. This requires translating the data in a way that will be meaningful.

Having information about both the individual residents and all residents is essential. QIs that give an overview or a summary of how a facility operates are very helpful. Accumulating summary information requires selecting the most important factors that occur in the majority of interactions at the point of care with residents. This often leads to an unfair criticism that the individual nuances of delivering and accepting care are lost. This is inherent in summarising data. There are also different methods for gathering this type of information.

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

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

- Point of care staff

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

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

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

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

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

- Residents, families and visitors

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

Not all QIs will be relevant to each individual resident.

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

What may not be visible are the systems of care for monitoring, maintaining and improving resident safety and quality.

Providing QI reports is an opportunity to showcase and explain the residential aged care facility's systems of care.

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

Setting targets – introduction

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

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

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

What are targets and how can they be set?

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

Achieving targets are processes to get to a predetermined level.

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

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

Realistic targets

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

Aspirational targets

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

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

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

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

Absolute targets

Absolute targets are the hardest of all to achieve.

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

Applying different targets

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

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

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

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

When thinking about targets:
Which do you prefer?
What do the residents prefer?
How will staff behave with the different targets?

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

Important questions for facilities include:
What is our quality goal in a particular area?
Is it to be good, better or best?
What targets will we use to measure and monitor how we get there?



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

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

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

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

Appendix 10 – Quality Indicators, the quality improvement cycle and continuous quality improvement

Factors that influence quality of care

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

Table 4: Factors that influence quality of care

Organisational capacity

This relates to the effectiveness of structures and systems in place for supporting safe high-quality care through strategic planning and leadership, risk management, workforce training, professional development, competency and accountability, information management, consumer engagement and participation, team work, culture, and communication.

Internal systems of care

This relates to how care is planned and organised so that is safe, effective, appropriate, integrated and coordinated, informed by evidence and person-centred so that quality of life is experienced by every resident every day.

Incident and adverse event management and escalation

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

External bodies

The functions of organisations external to residential facilities can directly influence or have an effect on resident safety and care outcomes. Examples of external organisations include professional registration bodies (for example AHPRA), accreditation agencies, the State Coroner's Office, and the Health Services Commissioner and Ombudsman.

Quality Indicators (QIs) and the quality improvement cycle

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

Use of the indicators should be considered as only one mechanism within a suite of improvement activities required for an effective quality system to improve safety, reduce preventable harm and support every resident to experience quality of life every day.

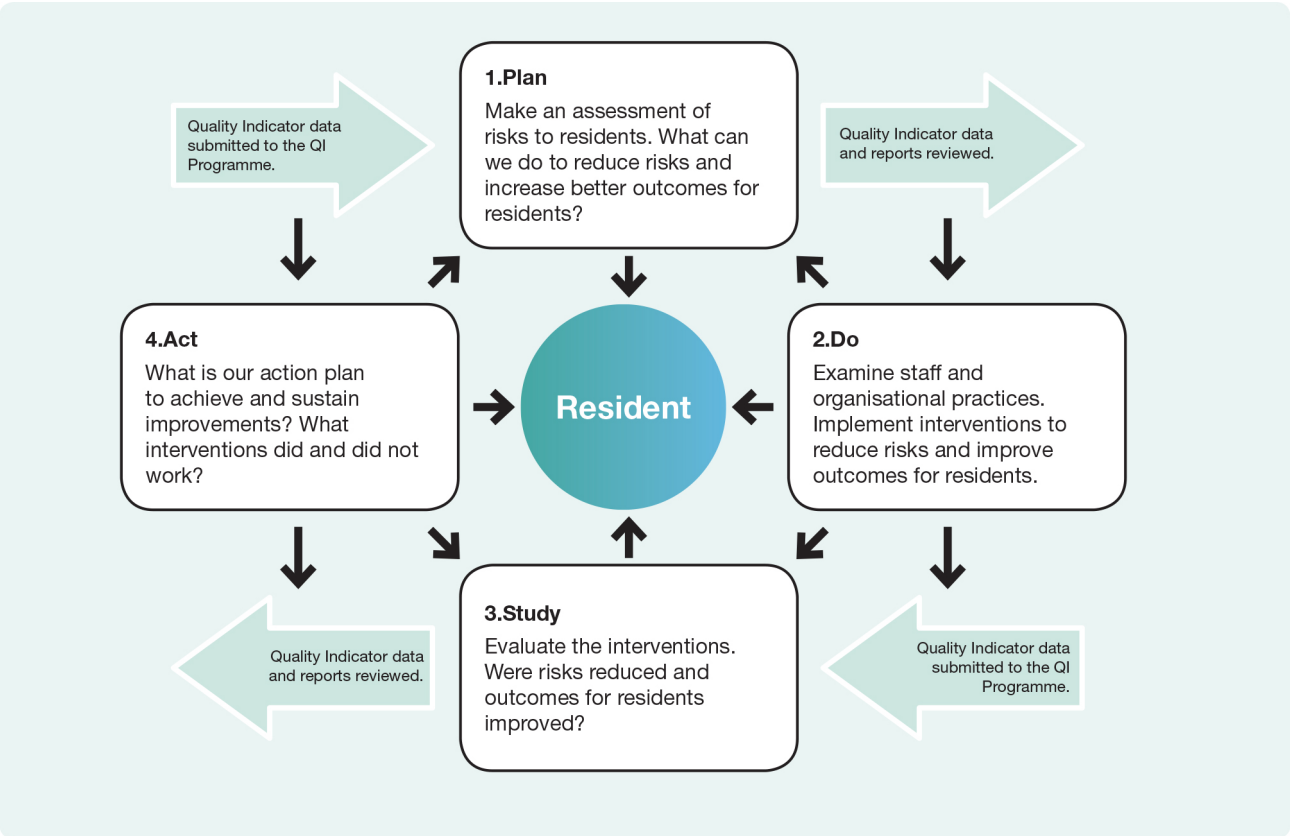
The QI Programme provides complementary information to that already gathered through different mechanisms such as complaints, incidents, adverse and sentinel events reporting, root cause analysis, surveys, audits (including structured clinical audits), process mapping, gap analysis, records review and adverse event screening, structured interviews, and administrative data.

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

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

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

Figure 10: Quality Indicators as part of the Plan, Do, Study, Act cycle



Appendix 11: Information for stakeholders including residents and families

Introduction

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

General practitioners

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

Clinical and care team

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

Resident and family

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

Board directors and executives

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

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



Information for general practitioners

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

The QI Programme measures different aspects of care.

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

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

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

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

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

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

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

Information sources

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

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

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

The role of general practitioners

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

Any changes to improve resident care will also require the involvement of general practitioners.

Facilities participating in the QI Programme need to respond proactively to QI information to continuously improve care.

Improving quality of life for residents

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

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

Other areas of care

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

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

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

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

Actions to take

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



Information for the clinical and care team

About the programme

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

The QI Programme measures different aspects of care.

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

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

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

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

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

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

Information sources

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

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

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

The role of the clinical and care team

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

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

Improving quality of life for residents

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

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

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

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

Other areas of care

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

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

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

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

Actions to take

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



Information for residents and families

About the programme

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

The QI Programme measures different aspects of care.

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

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

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

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

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

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

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

Information sources

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

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

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

The role of residents and families

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

Improving quality of life for residents

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

The managers, executive, care staff of the facility, and other health professionals (such as doctors) interpret and question the information and decide how improvements can be made. For example, if a facility's performance in the pressure injury indicator shows there are more pressure injuries than last year or there are more pressure injuries compared with the national average, this is an alert or a warning sign.

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

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

Other areas of care

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

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

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

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

Actions to take

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



Information for board directors and executives

About the Quality Indicator (QI) programme

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

The QI Programme measures different aspects of care.

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

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

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

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

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

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

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

Information sources

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

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

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

The role of the board and executive

The board and executive is responsible for the governance, leadership and oversight of safe, high quality resident care.

This includes ensuring that organisational responses to the quality data are appropriate, so:

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

Additional information

The board and executive will need information beyond that provided by the QI Programme. The QIs cover a limited number of areas which are high-priority risk areas for older people living in residential facilities.

Other information about care integration and effectiveness, and person-centeredness will need to be sourced from other parts of your governance systems, as well as information about other common and equally clinical risk areas such as constipation, falls, use of medicines, pain management and palliative care.

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* Please note that except for these references marked with an asterisk, all other references are cited in the Victorian Department of Health 2015, *Quality Indicators in public sector residential aged care services, Resource materials, January 2015 edition, Victorian Department of Health*.

NOTE: This reference list is extracted in full from the complete version of the *National Aged Care Quality Indicator Programme resource manual for residential aged care facilities, January 2016 edition*. It includes references from both Part A and Part B.

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All information in this publication is correct as of November 2015