Australian Government
Australian Institute of Health and Welfare

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AGED CARE DATA

Residential Aged Care Quality Indicators – October to December 2025

Technical notes

23 April 2026

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Suggested citation

Australian Institute of Health and Welfare (2026) *Residential Aged Care Quality Indicators – October to December 2025 Technical notes*, AIHW, Australian Government.

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Published by the Australian Institute of Health and Welfare.

Please note that there is the potential for minor revisions of data in this report. Please check the online version at gen-agedcaredata.gov.au for any amendments.

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National Aged Care Quality Indicator Program: 1 October to 31 December 2025

These notes provide general information about data arrangements and the AIHW's collation, processing and reporting of residential aged care quality indicators (QIs).

Data collection and transmission to AIHW

In accordance with the QI Program Manual from 1 April 2023, all Australian Government-subsidised residential aged care providers are required to collect specified data at the home level and submit these via the QIs App in the Government Provider Management System (GPMS) to the Department of Health, Disability and Ageing (the Department). With the prior agreement of the Department, homes can submit data through a commercial benchmarking company. Submission of the QI raw data is required by the 21st day of the month after the end of each quarter.

Since 1 July 2023 the AIHW has been contracted by the Department for the provision of computation and reporting services for the QI Program. Throughout the life of this contracted period, the Department have provided the QI data to the AIHW. Raw QI data and Quarterly Financial Report (QFR) data for the quarter 1 October to 31 December 2025 were provided to the AIHW on 11 February and 16 February 2026, respectively, via secure data transfer from the Department.

Numerator data and QI interpretation

In interpreting the QIs in this report it is important to consider the way in which they were measured. Most QIs in this report are measured during specified assessment windows (e.g., restrictive practices are assessed during a review of three days of records in the quarter). The results for some QIs may therefore not represent the occurrence of those events across other, non-assessed periods in the quarter.

In addition, by definition, the QIs in this report provide information about whether a resident or staff member met the criteria for the QI during the quarter or assessment window. The QI measure does not provide information about the frequency or duration of that measure (e.g., frequency or duration of restrictive practices, number of falls, duration of polypharmacy, or the time between an allied health service being recommended and received).

Denominator data and QI construction

In accordance with the QI Program Manual, QIs are constructed using different measurement approaches to reflect key aspects of care reported by residential care homes (RCH). The following sections outline five groups of QIs, each with distinct calculation methods.

QIs that measure the percentage of residents reported by RCH as meeting QI criteria

This group include:

- QIs 1–8: Pressure injuries, restrictive practices, unplanned weight loss, falls and major injury, medication management, activities of daily living, incontinence care, and hospitalisation
- QIs 10–11: Consumer experience and Quality of life

The total number of residents meeting the criteria to be counted for these QIs is divided by the total number of residents assessed at the home who do not meet exclusion criteria (referred to throughout this report as 'eligible residents') and multiplied by 100 to construct each QI category.

For these QIs, the percentage value was derived using the following formula:

$$\text{QI value} = \frac{\begin{array}{c}\text{The total number of residents meeting the criteria} \\ \text{to be counted (affirmative) for the QI}\end{array}}{\begin{array}{c}\text{The total number of residents assessed at the home} \\ \text{who do not meet exclusion criteria for the QI} \\ \text{(eligible residents)}\end{array}} \times 100$$

QIs that measure the percentage of staff reported by RCH as meeting the QI criteria

Workforce QI (QI 9) measures the percentage of staff that stopped working during the quarter. The number of staff reported to have stopped working during the quarter is divided by the total number of staff reported to have been employed at the beginning of the quarter.

For this QI, the percentage value was derived using the following formula:

$$\text{QI value} = \frac{\begin{array}{c}\text{The total number of staff reported} \\ \text{to have stopped working during the quarter}\end{array}}{\begin{array}{c}\text{The total number of staff reported to} \\ \text{have been employed at the beginning of the quarter}\end{array}} \times 100$$

QIs that measure the proportion of enrolled nursing care minutes in total care minutes

Enrolled nursing QI (QI 12) measure the proportion of care minutes delivered by enrolled nurses (ENs) and proportion of care minutes delivered by enrolled nurses and registered nurses.

- **Proportion of EN care minutes**: Proportion of EN care minutes per resident per day over total care minutes per resident per day. Total care minutes per resident per day (denominator) is the sum of care minutes per resident per day of EN, registered nursing (RN), and personal care workers or nursing assistants (PCW/NA).

For this QI, the proportion value was derived using the following formula:

$$\text{Proportion of EN care minutes per resident per day} = \frac{\text{Average EN care minutes per resident per day at reporting level (national, state and territory, or remoteness category)}}{\text{Average EN care minutes per resident per day} + \text{Average RN care minutes per resident per day} + \text{Average PCW/NA care minutes per resident per day, at reporting level}} \times 100$$

- **Proportion of nursing care minutes**: Proportion of combined EN and RN care minutes per resident per day over total care minutes per resident per day. Total care minutes per resident per day (denominator) is the sum of care minutes per resident per day of EN, RN, and PCW/NA.

  For this QI, the proportion value was derived using the following formula:

$$\text{Proportion of nursing care minutes per resident per day} = \frac{\text{Average EN and RN care minutes per resident per day at reporting level (national, state and territory, or remoteness category)}}{\text{Average EN care minutes per resident per day} + \text{Average RN care minutes per resident per day} + \text{Average PCW/NA care minutes per resident per day, at reporting level}} \times 100$$

QIs that measure care minutes per resident per day

QIs on allied health (QI 13 sub–item 1) and lifestyle officers (QI 14) care minutes per resident per day are calculated by dividing the total care minutes for the quarter (sum of direct staff and agency staff) by the occupied bed days (OBD) for the quarter from the QFR for RCH that reported these QIs.

For these QIs, the value of care minutes per resident per day was derived using the following formula:

$$\text{Average care minutes per resident per day} = \frac{\text{Direct staff care minutes} + \text{Agency staff care minutes}}{\text{Occupied bed days}}$$

In this report, aggregation for all QIs was across all RCH for the main tables, or disaggregated across state and territory and remoteness regions.

Home participation and estimated resident coverage

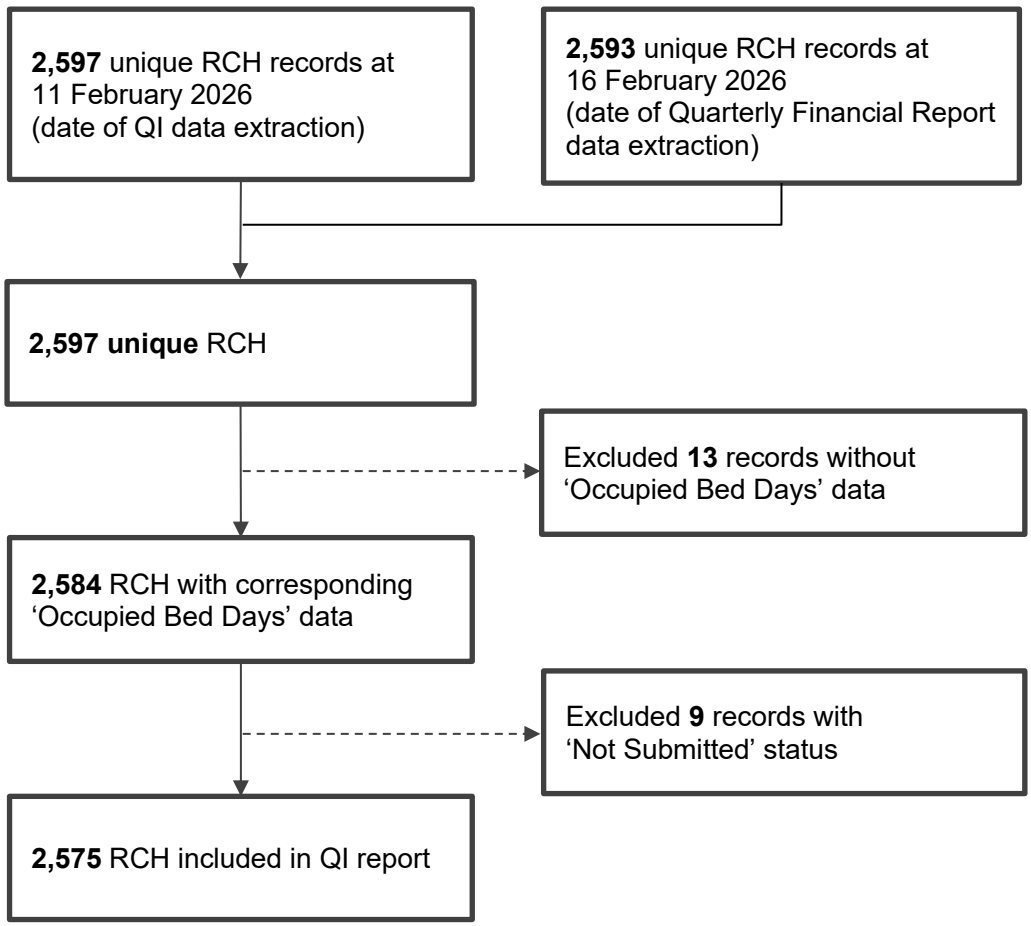
The QI Program collects QI data from ‘eligible residents’ or ‘eligible staff’ only, meaning that QI events or outcomes experienced by residents or staff who met exclusion criteria for QI measurement are not included in the statistics presented in this report. These exclusion criteria are further detailed in the National Aged Care Quality Indicator Program Manual (QI Program Manual).

For this quarter, providers were required to submit QI data to the Department by 21 January 2026. The QI raw data were then extracted by the Department on 11 February 2026, comprising data from 2,597 RCH with no duplicate records. The Department extracted data for care minute-related QIs from QFR on 16 February 2026, comprising data from 2,593 RCH with no duplicate records. All of the 2,593 records from QFR data could be linked with the 2,597 RCH in the extracted QI data. The unique RCH records were then filtered using OBD data provided within the QI data to derive an approximate denominator. Thirteen RCH were excluded due to not having available data about Australian Government subsidies for delivering care, services and accommodation (OBD data).

Of the remaining 2,584 RCH, 2,525 (97.7%) had a submission status of ‘Submitted’ (i.e., QI data were submitted on time), 49 (1.9 %) were ‘Submitted - Updated After Due Date’, 1 (~0.0%) were recorded as a ‘Late submission’ and 9 (0.4%) were recorded as ‘Not Submitted’. The 9 RCH with a ‘Not Submitted’ status were excluded from the analyses presented in this quarterly report.

The final data set included 2,575 RCH with at least some QI data submitted. Compared with the previous quarter, this represents a decrease in RCH included in this quarterly report of 0.2%. Of the included 2,575 RCH, 2,502 (97.2%) submitted QI data for all 12 QIs (QIs 1–12) detailed in this report, 72 (2.7%) submitted data for 10 or 11 QIs, and 1 (~0.0%) submitted data for 9 QIs. Of the 2,575 RCH, 2,545 RCH (98.8%) have care minute data included the QFR dataset.

Figure S1: Flow diagram of including residential care homes in the report



The QI Program's coverage of the estimated resident population ranged from 99.2% for proportion of enrolled nursing care minutes to 113.8% for hospitalisations (Table S1). It was not possible to calculate coverage for the Workforce QI, because population data for the aged care workforce are not available.

When interpreting these coverage data, it is important to note that the calculations are based on an approximation of the denominator using data that shows how many bed days were funded for each home in that period. While the numerator data for QIs measure one event per resident, the denominator data are calculated using an approximation – dividing the number of 'Occupied Bed Days' (OBD) for a quarter by the number of days in that quarter to get an estimate of how many residents occupied beds per quarter. This approximation assumes that residents occupy beds for the same number of days per quarter, but this may not be the case.

There are various reasons a resident may not occupy a bed for an entire quarter, including entering or exiting care mid-quarter. As the numerator and denominator for the coverage calculation are not aligned at the resident level, there is the possibility for proportions to exceed one hundred per cent. Additional factors contribute to the misalignment of the numerator and denominator, including lagged claims, retrospective adjustments, measurement timings, absent residents (e.g. hospitalisations) and resident deaths. It should also be noted that in the interests of timeliness for the release of this quarterly report, the preliminary OBD data extracted on 11 February 2026 was used in the analysis; prior to finalisation of the quality assurance of these data by the Department. Preliminary data is considered robust for this purpose as only minor changes to data are expected after the quality assurance process since the date of OBD data extraction.

The number of residents excluded (Table S1, Columns C and D) was highest for quality of life (33.2%) and consumer experience (33.7%). For these QIs, the most common reason for exclusion was that the resident did not choose to complete the survey.

Table S1: Estimated resident coverage and exclusions in the RCH QI Program, October to December 2025

QI	Estimated resident coverage in QI Program		Exclusions and measurements of residents in QI Program		
	Residents assessed for QI eligibility in included RCH* (A)	Coverage of estimated resident population in all RCH (B)	Residents excluded due to not providing consent (C)	Residents excluded due to ineligibility (D)	Residents eligible for QI measurement (E)
Pressure injuries	214,369	107.2%	1,633 (0.8%)	366 (0.2%)	212,370 (99.1%)
Restrictive practices	208,172	104.1%	N.A.	1,838 (0.9%)	206,334 (99.1%)
Unplanned weight loss – significant	225,529	112.8%	5,251 (2.3%)	45,020 (20.0%)	175,258 (77.7%)
Unplanned weight loss – consecutive	225,739	112.9%	6,294 (2.8%)	48,146 (21.3%)	171,299 (75.9%)
Falls and major injury	225,634	112.9%	N.A.	270 (0.1%)	225,364 (99.9%)
Medication management – polypharmacy	207,120	103.6%	N.A.	1,332 (0.6%)	205,788 (99.4%)
Medication management – antipsychotics	207,330	103.7%	N.A.	706 (0.3%)	206,624 (99.7%)
Activities of daily living	220,876	110.5%	N.A.	28,396 (12.9%)	192,480 (87.1%)
Incontinence	213,175	106.7%	N.A.	742 (0.3%)	212,433 (99.7%)
Incontinence associated dermatitis	213,175	106.7%	N.A.	53,513 (25.1%)	159,662 (74.9%)
Hospitalisation	227,535	113.8%	N.A.	932 (0.4%)	226,603 (99.6%)
Workforce**	N.A.	N.A.	N.A.	N.A.	N.A.
Consumer experience	204,634	102.4%	64,861 (31.7%)	3,149 (1.5%)	136,624 (66.8%)
Quality of life	205,598	102.9%	66,138 (32.2%)	2,992 (1.5%)	136,468 (66.4%)
Allied health recommended services received	224,054	112.1%	N.A.	691 (0.3%)	223,363 (99.7%)
EN care minutes	198,268	99.2%	N.A.	N.A.	198,268 (100.0%)
AH care minutes	198,399	99.3%	N.A.	N.A.	198,399 (100.0%)
Lifestyle officers care minutes	198,399	99.3%	N.A.	N.A.	198,399 (100.0%)

Notes:
* Included RCH were those that had submitted QI data by the date of extraction and received Australian Government subsidies for delivering care, services, and accommodation in the quarter. Homes not meeting these criteria, and the residents that may or may not have been assessed for QI eligibility at those homes, were excluded from these calculations. **A** (*Residents assessed for QI eligibility in included* RCH), and therefore **B** (*Coverage of estimated resident population in all RCH*), is higher than these figures when these excluded RCH are included (data not shown). Reasons for ineligibility for measurement differ by QI and are detailed in the QI Program Manual.
** It is not possible to calculate estimations of coverage for the Workforce QI because population data are not available.
A (*Residents assessed for QI eligibility in included RCH*) was calculated as the sum of **C** (*Residents excluded due to not providing consent*), **D** (*Residents excluded due to ineligibility*) and **E** (*Residents eligible for QI measurement*).
B (*Coverage of estimated resident population in all RCH*) was calculated by dividing **A** (*Residents assessed for QI eligibility in included RCH*) by an estimate of the total RCH resident population for this quarter (199,882) residents—calculated by summing the total number of 'Occupied Bed Days' (OBD) for which an Australian Government residential aged care subsidy was claimed by all RCH and dividing by the number of days in the quarter).
Percentages in **C**–**E** are in relation to values in **A** (*Residents assessed for QI eligibility in included RCH*).
N.A., not applicable.
Source: Department of Health, Disability and Ageing, QI and OBD data extracted 11 February 2026, published on https://www.gen-agedcaredata.gov.au/

Geographic characteristics

Two separate disaggregations are reported for the location of RCH—state and territory and remoteness. State and territory were taken from location address information reported on the QI data file and reflects standard sub-national administrative areas.

The QI data set was merged with home-level data from the National Aged Care Data Clearinghouse (NACDC) as at 30 June 2025 (the latest available) to bring the QI data together with the Modified Monash Model (MMM) 2019 remoteness classifications for the analysis presented in this report. This merge used as its linkage key the National Approved Provider System (NAPS) home identification number, the identifier used in the NACDC. In this step, 2,572 of the 2,575 included records matched with a home identified in the NACDC. Three records did not match with the NACDC home list but could be matched to MMM using the MMM 2019 list.

Remoteness was based on the MMM 2019 classifications obtained from the NACDC collapsed into 3 categories—metropolitan areas (MM1); regional centres (MM2); and a category combining large rural towns (MM3), medium rural towns (MM4), small rural towns (MM5), remote communities (MM6) and very remote communities (MM7).

Note that the QI data presented in this report are not risk adjusted for the varying case-mix of home populations. Caution should be exercised in interpreting and comparing QIs in states and territories where smaller populations mean fewer homes, such as NT, ACT and TAS, and small differences in counts of QIs from quarter to quarter can cause fluctuations in QI percentages across quarterly reporting.

Coherence, inconsistencies, and outliers in calculated QIs

This data collection was conducted under the National Aged Care Quality Indicator Program Manual, which has been in place since 31 October 2025. The QI Program Manual counts the number of residents meeting QI criteria and produces prevalence rates in the form of percentages. This value is calculated by dividing the number of eligible residents that meet the criteria to be counted for the QI by the total number of eligible residents assessed for that QI and then multiplying by 100.

Due to reporting requirements, measurement and reporting factors, the AIHW does not undertake any data cleaning prior to compiling the figures in this report. For example, QI data are submitted by RCH as aggregated data at the home level and there is no process for independent monitoring or validation against source data. Therefore, the AIHW has no firm basis for determining that an apparent ‘outlier’ (i.e. extreme value) in the distribution of QIs across RCH represents an incorrect data point.

The Department has implemented a QI Assurance Program that will review a proportion of QI data submissions against home source data on a quarterly basis. It will use both a targeted and random sampling approach of homes and resident data, to increase the reliability of future QI data submissions. These reviews will occur quarterly following public reporting and may result in resubmissions to correct data.

Some variation in the total number of residents assessed in a RCH against each of the QIs can be expected given that measurements for different QIs can occur at different times within the quarter, and each QI has different exclusion criteria. However, the magnitude of this

variation for some RCH points to possible data entry errors or misinterpretation of the QI Program Manual or reporting template. While in certain situations the reporting of 100% prevalence for a QI may be plausible, in others it may indicate under-reporting of the number of residents assessed or over-reporting of the number of residents who met the criteria for the QI. Rates of 100% and 0% monitored in this report is to identify any such data quality issues.

For QIs where higher percentages indicate poorer performance, 100% prevalence reporting was most common for workforce (0.7%) and restrictive practices (0.5%). This is expected for restrictive practices QI as some homes that have reported 100% for restrictive practices are specialist dementia or mental health services within a locked facility. Therefore, all residents in these homes would be assessed as using of a restrictive practice exclusively through the use of a secure area (as per the manual). For QIs where higher percentages indicate better performance, 100% prevalence reporting was most common for allied health recommended services received (42.8%) (Table S2). Some RCH reported zero residents meeting the criteria for individual QIs, which varied between QIs (Table S2).

Table S2. Selected RCH reporting characteristics in the QI Program, October to December 2025

QI	Number of RCH that reported 100% QI rate	Percentage of RCH that reported 100% QI rate	Number of RCH that reported 0% QI rate	Percentage of RCH that reported 0% QI rate
One or more pressure injuries	0	0.0%	256	9.9%
Restrictive practices	13	0.5%	310	12.0%
Unplanned weight loss – significant	0	0.0%	151	5.9%
Unplanned weight loss – consecutive	2	0.1%	150	5.8%
Falls – falls (total)	2	0.1%	3	0.1%
Falls – falls that resulted in major injury	0	0.0%	864	33.6%
Medication management – polypharmacy	2	0.1%	3	0.1%
Medication management – antipsychotics	9	0.3%	16	0.6%
Activities of daily living	0	0.0%	94	3.7%
Incontinence associated dermatitis	4	0.2%	692	26.9%
Hospitalisation – emergency department presentations	2	0.1%	107	4.2%
Hospitalisation – emergency department presentations or hospital admissions	3	0.1%	34	1.3%
Workforce	18	0.7%	590	22.9%
Consumer experience	379	14.7%	1	0.0%
Quality of life	180	7.0%	1	0.0%
Allied health recommended services received	1,101	42.8%	3	0.1%

Trend analysis

Regression model

Analysis to examine trends in QIs over time was conducted using a quasi-Poisson regression model. Poisson regression is commonly used to model counts and rates. With a traditional Poisson regression model, we would expect the conditional means and variances of the event counts to be about the same in various groups. To account for potential over-dispersion (e.g. where the variance is larger than the mean) in the data, a quasi-Poisson regression method as outlined in Formula 1 was used to examine the long-term trend in aggregated QIs over all quarters of available data, i.e. since Q1 (July to September) 2021-22 to the latest quarter Q2 (October to December) 2025-26. Quasi-Poisson regression fits an extra dispersion parameter to account for the extra variance. Models were fitted in R 4.2.2 using the glm() function with family = "quasipoisson".

$$\log(Y_{i,j}) = \log(n_{i,j}) + \beta_0 + \beta_1 t_j$$

Formula 1. Quasi-Poisson regression model

Where:

- $Y_{i,j}$ = the count of residents who meet the criteria for QI *i* (one or more pressure injuries, restrictive practices, significant unplanned weight loss, consecutive unplanned weight loss, polypharmacy, antipsychotics) in quarter *j*.
- β_0, β_1 = fitted regression coefficients
- t_j = quarter number *(i.e., t_j = 1, 2, …, J;* where *J* is the total number of quarters of available data*)*
- $n_{i,j}$ = the number of residents assessed for QI *i* in quarter *j*.

Differences in numbers of residents assessed by each home are considered by including an **offset** in the model ($\log(n_{i,j})$) so that the resident count is adjusted to be comparable across homes of different sizes.

Interpreting risk ratios

A quasi-Poisson regression model generates risk ratios. In this analysis, risk ratios describe the average change in QI performance per quarter (Table S3). A risk ratio greater than 1.0 indicates an increasing trend over time, and a risk ratio less than 1.0 indicates a declining trend over time. 95% confidence intervals indicate the precision of the risk ratio. Where a 95% confidence interval crosses 1.0, this indicates that the risk ratio is not statistically significant to $p < 0.05$ and there has been no meaningful change in QI performance over time.

For example:

- A risk ratio of 0.975 indicates that the prevalence proportion of aged residents who experienced the event **declined** by an average of 100 x (1-0.975) = 2.5% per quarter over the reporting period. A 95% confidence interval (0.968-0.982) tells us that there is a 95% likelihood that the true average decline per quarter lies between 1.8% and 3.2%.

- A risk ratio of 1.014 indicates that the prevalence proportion of aged residents who experienced the event **increased** by an average of 100 x (1.014-1) = 1.4% per quarter over the reporting period. A 95% confidence interval (1.009-1.021) tells us that there is a 95% likelihood that the true average increase per quarter lies between 0.9% and 2.1%

Note that trend analyses are unadjusted and therefore do not consider factors that may influence QI performance (e.g. home size, type, location).

In modelling with large sample sizes, even very small differences over time can be statistically significant. It is important to consider clinical significance (i.e. real-world impact) of the change.

Count data used for trend analysis

The trend analysis uses quarterly count data that has been aggregated across all homes to fit the model. The aggregated count data accounts for variability within the data over time.

For a given QI, the quarterly aggregated data consist of:

- the total number of all residents meeting the criteria for the QI in each quarter
- the total number of residents assessed for the QI in each quarter summed over all homes that submitted QI data.

References

Department of Health, Disability and Ageing (2025) *Modified Monash Model*, Department of Health, Disability and Ageing website, Australian Government, assessed 2 April 2026.

Department of Health, Disability and Ageing (2025) *National Aged Care Quality Indicator Program Manual (November 2025)*. Department of Health, Disability and Ageing, Australian Government, assessed 2 April 2026.