QIs Apr – Jun 2022

Residential Aged Care Quality Indicators—April to June 2022

Quality indicators (QI) measure aspects of service provision that contribute to the quality of care given by residential aged care services (RACS). Since 1 July 2019, participation in the National Aged Care Mandatory Quality Indicator Program (QI Program) has been a requirement for all Australian Government-subsidised RACS. Until 30 June 2021, the QI Program included 3 QIs (pressure injuries, use of physical restraint, unplanned weight loss). Since 1 July 2021, the QI Program requires these services to report on 5 QIs:

- Pressure injuries
- Use of physical restraint
- Unplanned weight loss
- Falls and major injury
- Medication management

While the original QI Program counted occurrences of pressure injuries, unplanned weight loss and use of physical restraint devices (meaning that more than one pressure injury or physical restraint device could be counted for a single care recipient), the expanded QI Program from 1 July 2021 counts the number of care recipients meeting/not meeting QI criteria and produces prevalence rates in the form of percentages. This value is calculated by dividing the number of eligible care recipients that meet the criteria to be counted for the QI by the total number of eligible care recipients assessed and then multiplying by 100.

Not all care recipients are counted in each QI measurement. Care recipients may be excluded from QIs for various reasons, such as not consenting to being assessed or have their data collected (for applicable QIs), being absent from the service during the QI assessment period, or receiving end-of-life care. Consent is required from care recipients for the purposes of two QIs only: unplanned weight loss and pressure injuries. The reasons for other exclusions differ by QI and are detailed in the *National Aged Care Mandatory Quality Indicator Program Manual 2.0 - Part A* (QI Program Manual). The care recipients eligible to contribute to QI measurements are those in the total care recipient population who remain after subtracting ineligible care recipients (including those that do not provide consent).

Most QIs in this report are measured during specified assessment windows (e.g. use of physical restraint is 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. Further detail on each QI, including its rationale and measurement, can be found in the QI Program Manual. More information on the QI Program is available from the Department of Health and Aged Care.

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This quarterly report includes QI measurements from the fourth data collection conducted under the expanded QI Program (1 April to 30 June 2022) for 2,268 residential aged care services (RACS). These RACS are those that had received Australian Government subsidies for delivering care, services and accommodation in that period; had submitted QI data by the due date (21 July 2022); and had not amended these data by the date of QI data extraction (11 August 2022). This represented 85% of the 2,683 RACS that received these government subsidies in the quarter (a decrease from 92% in the previous quarter). Further detail on the care recipient coverage of the QI Program in this quarter, including counts of care recipient measurements and exclusions for each QI, is presented in Table 1 of the Technical notes.

Quality indicator definitions

Quality Indicator 1: Pressure injuries

A pressure injury is a localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, shear, or a combination of these factors. Assessment of pressure injuries in eligible care recipients is made on or around the same time and day in each quarter of the year. This can be done as part of the care recipient's usual personal care. Consent is sought from care recipients before a full-body observation assessment is undertaken.

Eligible care recipients with one or more pressure injuries are reported against each of the six pressure injury stages:

- **Stage 1** pressure injuries: intact skin with non-blanchable redness of a localised area.
- **Stage 2** pressure injuries: partial-thickness skin loss presenting as a shallow open ulcer with a red/pink wound bed.
- **Stage 3** pressure injuries: full-thickness skin loss, no exposure of bone, tendon or muscle.
- **Stage 4** pressure injuries: full-thickness loss of skin and tissue with exposed bone, tendon or muscle.
- **Unstageable** pressure injuries: full-thickness skin tissue loss in which the base of the injury is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black).
- **Suspected deep tissue** injuries: purple or maroon localised area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear.

Additional reporting: Eligible care recipients with pressure injuries that were acquired outside of the service during the quarter are counted separately but are still included in the total number of care recipients reported as having pressure injuries.

Quality Indicator 2: Use of physical restraint

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

The QI Program use of physical restraint indicator measures and reports data relating to all restrictive practice, excluding chemical restraint. This includes physical restraint, mechanical restraint, environmental restraint and seclusion.

It is a legal requirement for RACS to document all instances of physical restraint (see Part 4A of the Quality of Care Principles). For this QI in each quarter, three days of existing records for all eligible care recipients at a service are assessed for any instances of physical restraint. This indicator is therefore a measure of the use of physical restraint across the three-day period only. This three-day period is selected and recorded by providers but must be varied each quarter and not known to the staff directly involved in care.

Use of physical restraint are still recorded even if a care recipient or their representative has provided consent for the use of the restraint.

Additional reporting: Eligible care recipients physically restrained exclusively through the use of a secure area are counted separately but are still included in the total number of care recipients reported as being physically restrained.

Quality Indicator 3: Unplanned weight loss

Weight loss is considered to be unplanned where there is no written strategy and ongoing record relating to planned weight loss for the care recipient. Eligible care recipients are weighed each month around the same time of the day and wearing clothing of a similar weight (e.g. a single layer without coats or shoes). Consent is sought from care recipients before an assessment on their body weight is undertaken.

This indicator includes two categories:

- **Significant unplanned weight loss:** Eligible care recipients who experienced significant unplanned weight loss of 5% or more when comparing their current and previous quarter finishing weights.
- **Consecutive unplanned weight loss:** Eligible care recipients who experienced consecutive unplanned weight loss every month over three consecutive months of the quarter.

Quality Indicator 4: Falls and major injury

A fall is an event that results in a person coming to rest inadvertently on the ground or floor or other lower level. For a fall to meet the criteria of resulting in a major injury, the fall must result in one or more of the following: bone fractures, joint dislocations, closed head injuries with altered consciousness and/or subdural haematoma. Assessment for falls and major injury is conducted through a single review of the care records of each eligible care recipient for the entire quarter.

This indicator includes two categories:

- **Falls**: Eligible care recipients who experienced a fall (one or more) at the service during the quarter.
- **Falls that resulted in major injury:** Eligible care recipients who experienced a fall at the service, resulting in major injury (one or more), during the quarter.

Quality Indicator 5: Medication management

Assessment for polypharmacy is conducted through a single review of medication charts and/or administration records for each eligible care recipient for a collection date selected by the service every quarter. For antipsychotics, a seven-day medication chart and/or administration record review is conducted for each eligible care recipient every quarter.

This indicator includes two categories:

- **Polypharmacy:** Eligible care recipients who were prescribed nine or more medications as at the collection date in the quarter.
- **Antipsychotics:** Eligible care recipients who received an antipsychotic medication during the seven-day assessment period in the quarter.

Additional reporting: Eligible care recipients who received an antipsychotic medication for a diagnosed condition of psychosis are counted separately but are still reported in the total number of care recipients who received an antipsychotic medication.

National data

Quality indicator data are presented below at a national level. The table presents data for all eligible care recipients aggregated across all 2,268 included RACS. The boxplot that follows presents data for all eligible care recipients aggregated at the service level. For further information on boxplots, see ‘Interpreting boxplots’ below.

Table 1: Pressure injuries in residential aged care, April to June 2022

Indicator category	Number of care recipients with one or more pressure injuries acquired outside the service	Total number of care recipients with one or more pressure injuries	Proportion of care recipients with one or more pressure injuries
One or more injuries	1,540	10,670	6.3%
Stage 1	540	4,295	2.5%
Stage 2	669	4,968	2.9%
Stage 3	168	840	0.5%
Stage 4	66	250	0.1%
Unstageable	167	729	0.4%
Suspected deep tissue	85	422	0.2%

Note: 169,162 eligible care recipients were assessed for pressure injuries at the 2,268 included RACS. The total number of care recipients with one or more pressure injuries includes pressure injuries acquired both inside and outside the service.

Source: GEN-agedcaredata.gov.au

Table 2: Use of physical restraint in residential aged care, April to June 2022

Indicator category	Number of care recipients physically restrained exclusively through the use of a secure area	Total number of care recipients restrained	Proportion of care recipients restrained
Use of physical restraint	28,023	35,583	21.5%

Note: 165,404 eligible care recipients were assessed for use of physical restraint at the 2,268 included RACS. The total number of care recipients physically restrained includes care recipients physically restrained exclusively through the use of a secure area and care recipients physically restrained not exclusively through the use of a secure area.

Source: GEN-agedcaredata.gov.au

Table 3: Unplanned weight loss in residential aged care, April to June 2022

Indicator category	Number of care recipients with unplanned weight loss	Proportion of care recipients with unplanned weight loss
Significant unplanned weight loss	13,490	9.4%
Consecutive unplanned weight loss	13,072	9.4%

Note: 144,095 eligible care recipients were assessed for significant unplanned weight loss and 138,730 eligible care recipients were assessed for consecutive unplanned weight loss at the 2,268 included RACS.

Source: GEN-agedcaredata.gov.au

Table 4: Falls and falls that resulted in major injury in residential aged care, April to June 2022

Indicator category	Number of care recipients with recorded falls	Proportion of care recipients with recorded falls
Falls (total)	57,855	32.2%
Falls that resulted in major injury	3,961	2.2%

Note: 179,732 eligible care recipients were assessed for falls and major injuries at the 2,268 included RACS. The total number of falls includes falls resulting in major injury and falls not resulting in major injury.

Source: GEN-agedcaredata.gov.au

Table 5: Medication management—polypharmacy in residential aged care, April to June 2022

Indicator category	Number of care recipients who were prescribed nine or more medications	Proportion of care recipients who were prescribed nine or more medications
Polypharmacy	62,131	37.3%

Note: 166,740 eligible care recipients were assessed for polypharmacy at the 2,268 included RACS.

Source: GEN-agedcaredata.gov.au

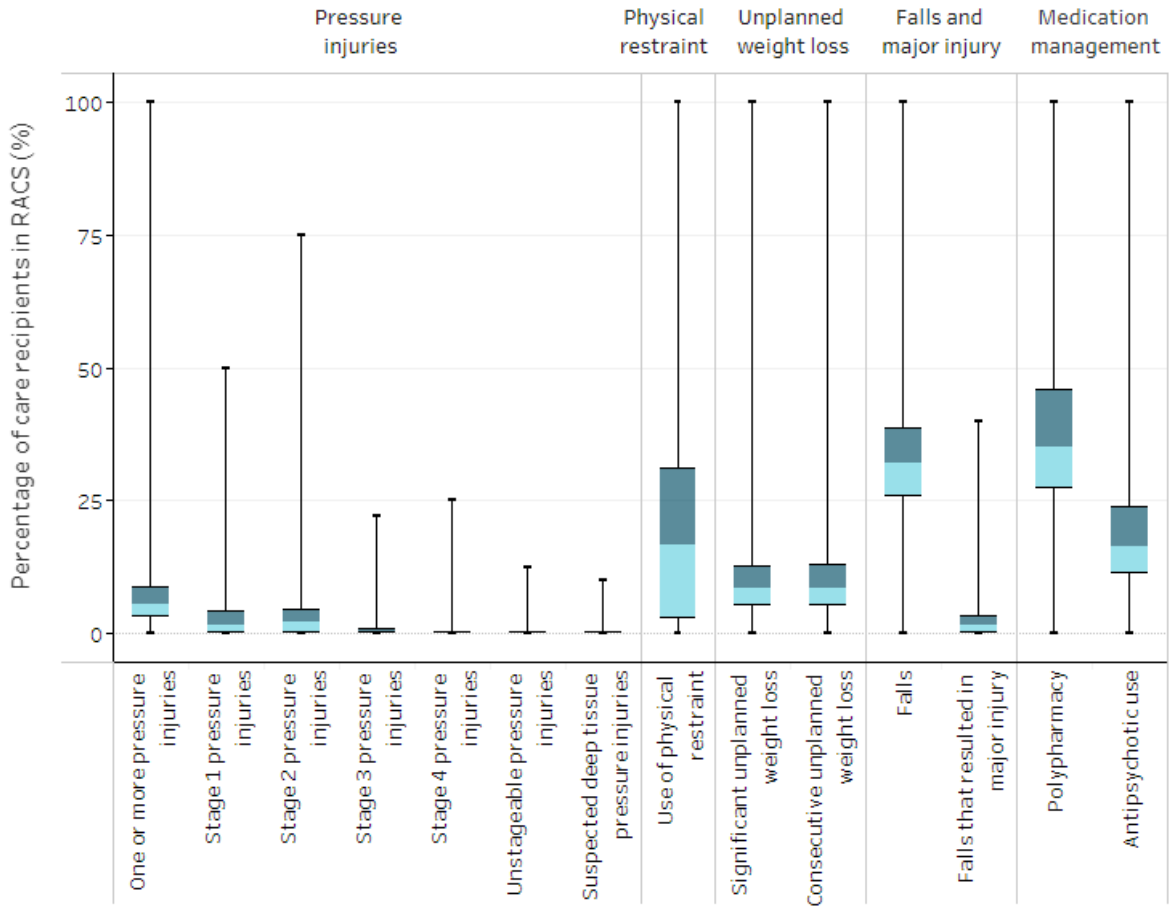
Table 6: Medication management—antipsychotics in residential aged care, April to June 2022

Indicator category	Number of care recipients who received an antipsychotic medication	Proportion of care recipients who received an antipsychotic medication
Use of antipsychotics (total)	32,115	19.3%
Antipsychotic use with diagnosed psychosis	17,339	10.4%

Note 166,752 eligible care recipients were assessed for antipsychotic use at the 2,268 included RACS. The total use of antipsychotics includes care recipients who received an antipsychotic medication with diagnosed psychosis and care recipients who received an antipsychotic medication without diagnosed psychosis.

Source: GEN-agedcaredata.gov.au

Boxplot—percentage of care recipients reported by RACS as meeting criteria for quality indicators, April to June 2022



Note: The number of RACS reporting 100% QI prevalence rates was small and ranged from 0%–1.9% of the 2,268 RACS included in this report. These outlying values have not been removed prior to compiling the statistics presented in this report because although some could reflect recording errors others could reflect valid data. See 'Technical notes' for more information on outliers and inconsistencies in calculated QIs.

GEN-agedcaredata.gov.au

Table 7: Percentage of care recipients reported by RACS as meeting criteria for quality indicators, April to June 2022

	Percentage of care recipients in RACS (%)				
Indicator	**Minimum**	**25th percentile**	**Median**	**75th percentile**	**Maximum**
One or more pressure injuries	0	3.0	5.4	8.7	100
Stage 1 pressure injuries	0	0	1.7	4.0	50.0
Stage 2 pressure injuries	0	0	2.2	4.4	75.0
Stage 3 pressure injuries	0	0	0	0.7	22.2
Stage 4 pressure injuries	0	0	0	0	25.0
Unstageable pressure injuries	0	0	0	0	12.5
Suspected deep tissue pressure injuries	0	0	0	0	10.0
Use of physical restraint	0	2.8	16.7	30.8	100
Significant unplanned weight loss	0	5.2	8.6	12.5	100
Consecutive unplanned weight loss	0	5.2	8.6	12.7	100
Falls	0	25.8	32.1	38.4	100
Falls that resulted in major injury	0	0	1.6	3.0	40.0
Polypharmacy	0	27.2	35.2	45.5	100
Antipsychotic use	0	11.4	16.3	23.5	100

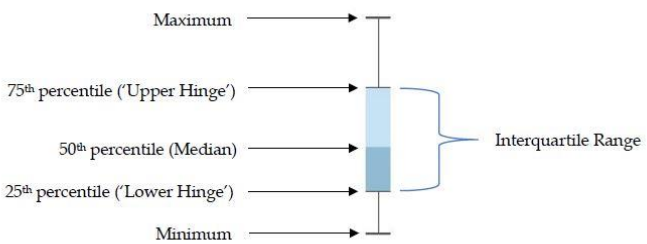
Note: The number of RACS reporting 100% QI prevalence rates was small and ranged from 0%–1.9% of the 2,268 RACS included in this report. These outlying values have not been removed prior to compiling the statistics presented in this report because although some could reflect recording errors others could reflect valid data. See 'Technical notes' for more information on outliers and inconsistencies in calculated QIs.

Interpreting boxplots

The values shown in the box plots are the **minimum** value, 25th percentile ('**Lower Hinge**'), the 50th percentile ('**Median'**), 75th percentile ('**Upper Hinge**') and the **maximum** value.

As an example of interpreting the percentiles, the 25th percentile shows at what QI prevalence rate 25% of the RACS reported a rate lower than this, and conversely 75% of the RACS reported a QI rate higher than this. The median value represents the QI prevalence rate in the middle of the values reported in Australia.

The interquartile range (IQR) is a measure of statistical dispersion or spread of QI rates and is the difference between the 75th percentile and the 25th percentile values.



Geographic variation

Disaggregations of QIs by state/territory and by remoteness categories were calculated from raw data with no risk adjustment. It has not been possible to take into account variation in the complexity of people's care needs at the facility level (casemix) nor how this interacts with other features known to vary across geographical areas, such as service size, facility ownership or interaction with healthcare services (such as hospitals and palliative care services).

Table 8a: Pressure injuries in residential aged care, percentage of care recipients, by state and territory, April to June 2022

Indicator category	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
One or more injuries	6.0%	6.4%	6.2%	5.1%	7.9%	8.1%	8.9%	4.2%	6.3%
Stage 1	2.2%	2.4%	2.9%	1.9%	3.3%	4.2%	4.1%	0.7%	2.5%
Stage 2	2.9%	3.1%	2.7%	2.4%	3.6%	3.4%	4.2%	2.8%	2.9%
Stage 3	0.5%	0.5%	0.4%	0.4%	0.8%	0.4%	0.6%	0.2%	0.5%
Stage 4	0.2%	0.1%	0.1%	0.1%	0.2%	0.1%	0.2%	0.0%	0.1%
Unstageable	0.5%	0.5%	0.3%	0.3%	0.4%	0.5%	0.5%	0.2%	0.4%
Suspected deep tissue	0.2%	0.3%	0.2%	0.3%	0.2%	0.1%	0.3%	0.7%	0.2%

Note: This table presents aggregate data for eligible care recipients at the 2,268 included RACS by state and territory. It includes data for pressure injuries acquired both inside and outside the service.

Source: GEN-agedcaredata.gov.au

Table 8b: Pressure injuries in residential aged care acquired outside the service, percentage of care recipients, by state and territory, April to June 2022

Indicator category	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
One or more injuries	1.0%	0.9%	0.8%	0.7%	1.1%	0.8%	1.1%	1.4%	0.9%
Stage 1	0.3%	0.3%	0.3%	0.2%	0.4%	0.4%	0.5%	0.2%	0.3%
Stage 2	0.4%	0.4%	0.3%	0.4%	0.5%	0.3%	0.4%	0.9%	0.4%
Stage 3	0.1%	0.1%	0.1%	0.1%	0.2%	0.1%	0.0%	0.0%	0.1%
Stage 4	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%
Unstageable	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%	0.1%	0.2%	0.1%
Suspected deep tissue	0.1%	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%	0.2%	0.1%

Note: This table presents aggregate data for eligible care recipients at the 2,268 included RACS by state and territory.

Source: GEN-agedcaredata.gov.au

Table 9: Use of physical restraint in residential aged care, percentage of care recipients, by state and territory, April to June 2022

Indicator category	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Physical restraint (total)	20.7%	19.5%	24.0%	24.6%	21.6%	15.1%	25.8%	16.9%	21.5%
Physical restraint exclusively through the use of a secure area	16.7%	16.7%	16.1%	20.3%	18.1%	11.0%	21.2%	9.6%	16.9%

Note: This table presents aggregate data for eligible care recipients at the 2,268 included RACS by state and territory. The total number of care recipients physically restrained includes care recipients physically restrained exclusively through the use of a secure area and care recipients physically restrained not exclusively through the use of a secure area.

Source: GEN-agedcaredata.gov.au

Table 10: Unplanned weight loss in residential aged care, percentage of care recipients, by state and territory, April to June 2022

Indicator category	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Significant unplanned weight loss	8.9%	9.4%	10.2%	10.2%	8.4%	8.8%	8.8%	8.8%	9.4%
Consecutive unplanned weight loss	8.9%	10.3%	9.4%	9.6%	9.2%	9.2%	7.7%	10.6%	9.4%

Note: This table presents aggregate data for eligible care recipients at the 2,268 included RACS by state and territory.

Source: GEN-agedcaredata.gov.au

Table 11: Falls and falls that resulted in major injury in residential aged care, percentage of care recipients, by state and territory, April to June 2022

Indicator category	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Falls (total)	31.1%	31.3%	32.3%	35.2%	36.2%	29.8%	33.8%	21.9%	32.2%
Falls that resulted in major injury	2.1%	2.0%	2.3%	2.5%	2.4%	3.1%	2.1%	1.5%	2.2%

Note: This table presents aggregate data for eligible care recipients at the 2,268 included RACS by state and territory. The total number of falls includes falls resulting in major injury and falls not resulting in major injury.

Source: GEN-agedcaredata.gov.au

Table 12: Medication management in residential aged care, percentage of care recipients, by state and territory, April to June 2022

Indicator category	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Polypharmacy	40.0%	37.4%	35.7%	36.2%	34.0%	30.6%	36.5%	19.4%	37.3%
Antipsychotics (total)	18.5%	21.1%	18.7%	20.4%	18.3%	17.1%	16.1%	24.0%	19.3%
Antipsychotics with diagnosed psychosis	9.7%	11.9%	10.7%	9.7%	9.9%	8.4%	8.3%	13.7%	10.4%

Note: This table presents aggregate data for eligible care recipients at the 2,268 included RACS by state and territory. The total use of antipsychotics includes care recipients who received an antipsychotic medication with diagnosed psychosis and care recipients who received an antipsychotic medication without diagnosed psychosis.

Source: GEN-agedcaredata.gov.au

Table 13a: Pressure injuries in residential aged care, percentage of care recipients, by remoteness, April to June 2022

Indicator category	Metropolitan (MM1)	Regional centres (MM2)	Rural and remote (MM3–MM7)	Aust
One or more injuries	6.1%	7.2%	6.7%	6.3%
Stage 1	2.3%	3.1%	3.1%	2.5%
Stage 2	2.9%	3.0%	3.0%	2.9%
Stage 3	0.5%	0.4%	0.5%	0.5%
Stage 4	0.1%	0.1%	0.2%	0.1%
Unstageable	0.5%	0.4%	0.4%	0.4%
Suspected deep tissue	0.3%	0.2%	0.2%	0.2%

Note: This table presents aggregate data for eligible care recipients at the 2,268 included RACS by Modified Monash Model (2019) classifications. It includes data for pressure injuries acquired both inside and outside the service.

Source: GEN-agedcaredata.gov.au

Table 13b: Pressure injuries in residential aged care acquired outside the service, percentage of care recipients, by remoteness, April to June 2022

Indicator category	Metropolitan (MM1)	Regional centres (MM2)	Rural and remote (MM3–MM7)	Aust
One or more injuries	0.9%	0.8%	0.9%	0.9%
Stage 1	0.3%	0.3%	0.3%	0.3%
Stage 2	0.4%	0.4%	0.4%	0.4%
Stage 3	0.1%	0.1%	0.1%	0.1%
Stage 4	0.0%	0.0%	0.1%	0.0%
Unstageable	0.1%	0.1%	0.1%	0.1%
Suspected deep tissue	0.1%	0.0%	0.0%	0.1%

Note: This table presents aggregate data for eligible care recipients at the 2,268 included RACS by Modified Monash Model (2019) classifications.

Source: GEN-agedcaredata.gov.au

Table 14: Use of physical restraint in residential aged care, percentage of care recipients, by remoteness, April to June 2022

Indicator category	Metropolitan (MM1)	Regional centres (MM2)	Rural and remote (MM3–MM7)	Aust
Physical restraint (total)	21.6%	19.9%	22.0%	21.5%
Physical restraint exclusively through the use of a secure area	17.1%	14.6%	17.5%	16.9%

Note: This table presents aggregate data for eligible care recipients at the 2,268 included RACS by Modified Monash Model (2019) classifications. The total number of care recipients physically restrained includes care recipients physically restrained exclusively through the use of a secure area and care recipients physically restrained not exclusively through the use of a secure area**.**

Source: GEN-agedcaredata.gov.au

Table 15: Unplanned weight loss in residential aged care, percentage of care recipients, by remoteness, April to June 2022

Indicator category	Metropolitan (MM1)	Regional centres (MM2)	Rural and remote (MM3–MM7)	Aust
Significant unplanned weight loss	9.4%	9.4%	9.1%	9.4%
Consecutive unplanned weight loss	9.5%	8.9%	9.3%	9.4%

Note: This table presents aggregate data for eligible care recipients at the 2,268 included RACS by Modified Monash Model (2019) classifications.

Source: GEN-agedcaredata.gov.au

Table 16: Falls and falls that resulted in major injury in residential aged care, percentage of care recipients, by remoteness, April to June 2022

Indicator category	Metropolitan (MM1)	Regional centres (MM2)	Rural and remote (MM3–MM7)	Aust
Falls (total)	32.6%	30.3%	31.7%	32.2%
Falls that resulted in major injury	2.1%	2.7%	2.3%	2.2%

Note: This table presents aggregate data for eligible care recipients at the 2,268 included RACS by Modified Monash Model (2019) classifications. The total number of falls includes falls resulting in major injury and falls not resulting in major injury.

Source: GEN-agedcaredata.gov.au

Table 17: Medication management in residential aged care, percentage of care recipients, by remoteness, April to June 2022

Indicator category	Metropolitan (MM1)	Regional centres (MM2)	Rural and remote (MM3–MM7)	Aust
Polypharmacy	37.7%	32.9%	37.5%	37.3%
Antipsychotics (total)	19.1%	18.2%	20.4%	19.3%
Antipsychotics with diagnosed psychosis	10.8%	9.3%	9.5%	10.4%

Note: This table presents aggregate data for eligible care recipients at the 2,268 included RACS by Modified Monash Model (2019) classifications. The total use of antipsychotics includes care recipients who received an antipsychotic medication with diagnosed psychosis and care recipients who received an antipsychotic medication without diagnosed psychosis.

Source: GEN-agedcaredata.gov.au

Technical notes

National Aged Care Mandatory Quality Indicator Program: 1 April to 30 June 2022.

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

The QI Program collects QI data from 'eligible care recipients' only, meaning that QI events or outcomes experienced by care recipients 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 Mandatory Quality Indicator Program Manual 2.0* (the Manual). Note that collection of QIs in this period was undertaken in the context of the ongoing COVID-19 pandemic in Australia.

Data collection and transmission to AIHW

In accordance with the Manual from 1 July 2021, all Australian Government-subsidised residential aged care providers are required to collect specified data at the service level and submit these via the My Aged Care Provider Portal to the Department of Health and Aged Care (the Department). With the prior agreement of the Department, services can submit data through a commercial benchmarking company. The QI raw data are required by the 21st day of the month after the end of each quarter.

Since 1 October 2020 the AIHW has been contracted by the Aged Care Quality and Safety Commission for the provision of computation and reporting services for the QI Program—formerly this relationship was with the Department of Health and Aged Care, who continue to provide the QI data to the AIHW. QI raw data for the quarter 1 April to 30 June 2022 were provided to the AIHW on 11 August 2022 by 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. use of physical restraint is 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 indicators in this report provide information about whether a care recipient met the criteria for the QI during the quarter or assessment window. The indicator measure does not provide information about the frequency or duration of that measure (e.g. frequency or duration of physical restraint, number of falls, duration of polypharmacy).

Denominator data and QI construction

In accordance with the Manual, the total number of care recipients meeting the criteria to be counted for the QI is divided by the total number of care recipients assessed at the service who do not meet exclusion criteria (referred to throughout this report as 'eligible care recipients') and multiplied by 100 to construct each QI category.

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

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

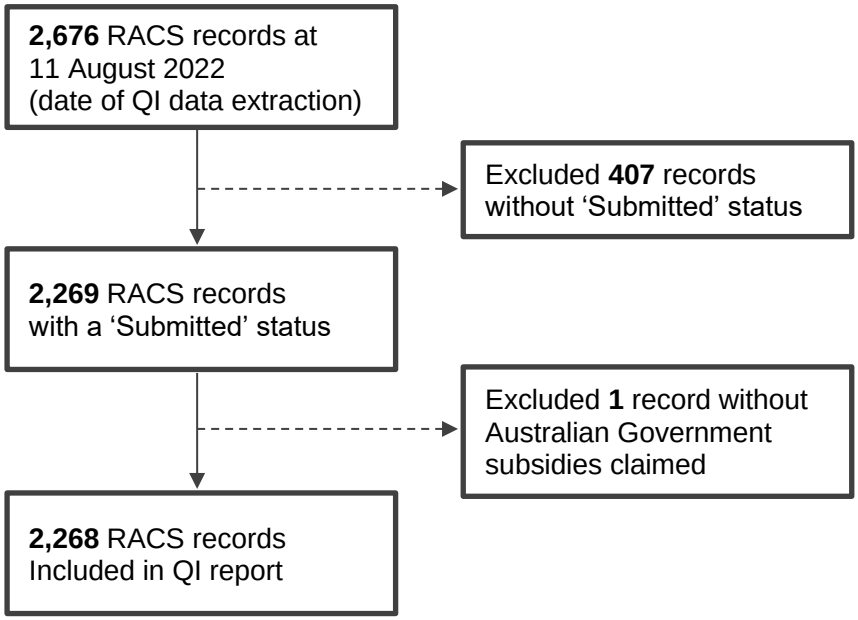
$$\text{QI value} = \frac{\text{The total number of care recipients meeting the criteria to be counted (affirmative) for the quality indicator (eligible care recipients)}}{\text{The total number of care recipients assessed at the service (who do not meet exclusion criteria for the quality indicator)}}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

Consolidating QI raw data

For the April to June 2022 quarter, no duplicate QI record was found.

Service response and care recipient coverage

For this quarter, providers were required to submit QI data to the Department by 21 July 2022. The QI raw data were then extracted by the Department on 11 August 2022. On that day, 2,269 (85%) records had a 'Submitted' submission status, 226 (8.4%) records were 'Updated after due date', 34 (1.3%) records were 'In progress', 27 (1.0%) records were 'Not started' and 120 (4.5%) records did not contain any QI data. The RACS analysed in this quarterly report include only those with a 'Submitted' status, 1 of which was excluded due to having not received Australian Government subsidies for delivering care, services and accommodation. The remaining 2,268 RACS had received these subsidies.



The 2,268 records with QI data available for national QI analysis represent 85% of the 2,682 RACS for which subsidy claims data had been provided for the quarter. Compared with the previous quarter, this is an absolute decrease in RACS included in this quarterly report of almost 8%. This decrease in RACS is primarily due to an issue experienced by some approved providers located in Victoria which resulted in their QI data being submitted after the due date (154 of the 226 RACS with a submission status of 'Updated after due date' excluded from this report were located in Victoria). Of the included 2,268 RACS, 2,224 (98%) submitted QI data for all QIs. Of the 44 RACS that did not submit data for all QIs, 41 (93%) submitted data for 4 of 5 QIs.

The QI Program's coverage of the estimated care recipient population ranged from 89% for use of physical restraint and medication management to 96% for falls and major injury (Table 1). This is a decrease in coverage from the previous quarter, which was estimated to range from 93.1% for use of physical restraint to 99.3% for falls and major injury.

The number of care recipients excluded due to ineligibility (Table 1, Column D) was highest for consecutive unplanned weight loss (18%) and significant unplanned weight loss (16%), consistent with the previous quarter. For these QIs, the most common reason for exclusion was the unavailability of care recipient records.

When interpreting these coverage estimates it is important to note that they are calculated using denominator data with observed inconsistencies as detailed in section 'Outliers and inconsistencies in calculated QIs'.

Table 1: Care recipient coverage and exclusions in the RACS QI Program, April to June 2022

Quality indicator	Estimated care recipient coverage in QI Program		Exclusions and measurements of care recipients in QI Program		
	Care recipients assessed for QI eligibility in included RACS* (A)	Coverage of estimated care recipient population in all RACS (B)	Care recipients excluded due to not providing consent (C)	Care recipients excluded due to ineligibility (D)	Care recipients eligible for QI measurement (E)
Pressure injuries	171,490	91.4%	1,834 (1.1%)	494 (0.3%)	169,162 (98.6%)
Use of physical restraint	166,925	89.0%	N.A.	1,521 (0.9%)	165,404 (99.1%)
Unplanned weight loss —significant	175,662	93.6%	2,746 (1.6%)	28,821 (16.4%)	144,095 (82.0%)
Unplanned weight loss —consecutive	174,034	92.8%	3,802 (2.2%)	31,502 (18.1%)	138,730 (79.7%)
Falls and major injury	180,353	96.1%	N.A.	621 (0.3%)	179,732 (99.7%)
Medication management — polypharmacy	167,731	89.4%	N.A.	991 (0.6%)	166,740 (99.4%)
Medication management — antipsychotics	167,557	89.3%	N.A.	805 (0.5%)	166,752 (99.5%)

Notes:

* Included RACS were those that had: submitted QI data by the due date and had not amended those data by the date of QI data extraction; and received Australian Government subsidies for delivering care, services and accommodation in the quarter. Services not meeting these criteria, and the care recipients that may or may not have been assessed for QI eligibility at those services, were excluded from these calculations. **A** (*Care recipients assessed for QI eligibility in included* RACS), and therefore **B** (*Coverage of estimated care recipient population in all RACS*), is higher than these figures when these excluded RACS are included (data not shown).

Reasons for ineligibility for measurement differ by QI and are detailed in the QI Program Manual.

A (*Care recipients assessed for QI eligibility in included RACS*) was calculated as the sum of **C** (*Care recipients excluded due to not providing consent*), **D** (*Care recipients excluded due to ineligibility*) and **E** (*Care recipients eligible for QI measurement*).

B (*Coverage of estimated care recipient population in all RACS*) was calculated by dividing **A** (*Care recipients assessed for QI eligibility in included RACS*) by an estimate of the total RACS care recipient population for this quarter (187,583 care recipients—calculated by summing the total number of 'Occupied Bed Days' for which an Australian Government residential aged care subsidy was claimed by all RACS and dividing by the number of days in the quarter).

Percentages in **C**–**E** are in relation to values in **A** (*Care recipients assessed for QI eligibility in included RACS*).

N.A., not applicable.

Service-level data from the National Aged Care Data Clearinghouse

The QI data set was merged with service-level data from the National Aged Care Data Clearinghouse (NACDC) as at 30 June 2021 (the latest available) to bring the QI data together with Modified Monash Model (2019) remoteness classifications for analysis presented in this report. This merge used as its linkage key the National Approved Provider System (NAPS) service identification number, the identifier used in the NACDC. In this step, 12 of the 2,268 records failed to match with a service identified in the NACDC. Remoteness category information was therefore manually added for these 12 RACS through matching the service suburb and postcode with the corresponding Modified Monash Model (2019) classification in a Department of Health and Aged Care data file.

Geographic characteristics

Two separate disaggregations are reported for the location of RACS—state/territory and remoteness. State/territory was taken from location address information reported on the QI data file and reflects standard sub-national administrative areas. Remoteness was based on the Modified Monash Model (MMM) 2019 collapsed into 3 categories—Metropolitan; Regional Centres; and a category combining Inner Regional, Outer Regional, Remote and Very Remote regions, and was obtained predominantly from the NACDC.

It is important to note that QI data presented by state/territory and remoteness are not risk-adjusted to account for possible differences in the care complexity of care recipients.

Outliers and inconsistencies in calculated QIs

This is the fourth data collection conducted under the *National Aged Care Mandatory Quality Indicator Program Manual 2.0.* RACS' familiarity with and adherence to the Manual is expected to improve over time.

Quality indicator reporting under the Manual 2.0 requires services to report the total number of eligible care recipients assessed for each QI, which is then used as the denominator when compiling QI percentages. This differs to the original QI Program, where QI rates were compiled using the number of care recipient days in which an Australian Government subsidy was claimed (referred to as 'Occupied Bed Days' in Manual 1.0).

The AIHW has noted in previous QI data reports that it has no firm basis for determining that an apparent 'outlier' in the distribution of QIs across RACS represents an incorrect data point. Therefore, no data cleaning is undertaken by AIHW prior to compiling the figures in this report.

While this remains the case, the AIHW will continue to conduct analysis to identify the most extreme upper-level outliers along the service size continuum, the extent of zero reporting and apparent internal inconsistencies that appear to reflect varied interpretation of reporting requirements. Consultation with the Aged Care Quality and Safety Commission on these matters may be expected to contribute, through education of providers and improvements to data collection methods, to improved quality of reporting and to development of the QI Program over time.

Some services included in this report had probable discrepancies in the total number of care recipients assessed for inclusion in each QI. While some variation in the total number of care recipients assessed in a RACS can be expected given that measurements for different QIs can occur at different times, the magnitude of this variation for some RACS points to possible data entry errors or misinterpretation of the Manual or reporting template.

Some services appeared to have only assessed and counted care recipients who met the criteria for that particular indicator, without accounting for those who were assessed but did not meet the criteria. For example, when assessing care recipients for use of physical restraint QI, some services only accounted for those who had been physically restrained, without accounting for those who had not been physically restrained. A service may have recorded 5 care recipients assessed as meeting the criteria for the use of physical restraint indicator out of 5 care recipients assessed (or 100%), rather than 5 care recipients assessed as meeting the criteria out of 81 assessed, 76 of whom were found not to meet the criteria (or 94%). This type of error means that QI percentages are overestimated for some RACS.

Although present in only a small proportion of RACS (less than one percent), some inconsistencies were observed in this quarter and in the previous quarters regarding how QIs (e.g. Antipsychotics) and their additional reporting categories (e.g. antipsychotic use for a diagnosed condition of psychosis) were recorded. By definition, data for QI totals (e.g. antipsychotics total) are inclusive of any additional reporting data (e.g. antipsychotics with diagnosed psychosis), but some services reported higher counts for an additional reporting category than for the corresponding QI.

The number of 100% prevalence rate reporting was highest for use of physical restraint (Table 2), consistent with the previous quarter. However, this was 0.6 percentage points lower than in the previous quarter (1.9% compared with 2.5%). Some RACS reported zero care recipients meeting the criteria for individual QIs, which varied between QIs substantially (Table 2).

Table 2. Selected RACS reporting characteristics in the Mandatory QI Program, April to June 2022

Quality indicator	Number of RACS that reported 100% QI rate	Percentage of RACS that reported 100% QI rate	Number of RACS that reported 0% QI rate	Percentage of RACS that reported 0% QI rate
One or more pressure injuries	3	0.1%	212	9.3%
Use of physical restraint	44	1.9%	443	19.5%
Significant unplanned weight loss	11	0.5%	132	5.8%
Consecutive unplanned weight loss	38	1.7%	152	6.7%
Falls	9	0.4%	15	0.7%
Falls that resulted in major injury	0	0.0%	741	32.7%
Polypharmacy	7	0.3%	7	0.3%
Antipsychotics	16	0.7%	28	1.2%

Note: Percentages are calculated in relation to 2,268 RACS

Conclusion

This is the fourth data collection under the *National Aged Care Mandatory Quality Indicator Program Manual 2.0* and the AIHW's fourth quarterly report on the expanded QI Program. An issue experienced by some approved providers located in Victoria, in their internal QI reporting processes, resulted in submission of data after the due date, 21 July 2022 (submission after the due date is an exclusion criterion). As a result, an overall decrease in on time submissions is observed nationally for this quarter. In this quarter, 85% of services that claimed Australian Government subsidies for delivering care, services and accommodation were included compared with 92% of services in the previous quarter. This resulted in a decrease at the national level in the coverage of the QI Program in terms of care recipients assessed.

Measurement and reporting factors impacting on data quality remain and some are described earlier in these technical notes. For example, QI data are submitted by residential aged care providers as aggregated data at the service level and there is no mechanism for independent monitoring or validation against source data. There are ongoing issues with outliers and inconsistencies in numerator and denominator data suggestive of misinterpretation or misapplication of the Manual in some cases. These measurement and reporting factors underpin AIHW's advice that caution should be exercised in interpreting compiled QI values. Caution also needs to be taken when interpreting changes in QI values across quarters, particularly when comparing QIs in less populated states and territories where small differences in counts of QIs can cause fluctuations in QI percentages from quarter to quarter. As a developing data collection, RACS familiarity with and adherence to the Manual is likely to be one of the key drivers of data variation, and this impact is expected to lessen over time as services become better acquainted with the new reporting requirements and data collection templates. Data comparisons over time may therefore in part reflect differences in evolving processes of data collection instead of changing care practices.

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