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GEN AGED CARE DATA

Residential Aged Care Quality Indicators– April to June 2025

Technical notes

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Australian Institute of Health and Welfare

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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.

Contents

National Aged Care Mandatory Quality Indicator Program: 1 April to 31 June 2025

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' or 'eligible staff' only, meaning that QI events or outcomes experienced by care recipients 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 Mandatory Quality Indicator Program Manual 4.0* (QI Program Manual).

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 service 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, services 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 these contracted periods, the Department have provided the QI data to the AIHW. Raw QI data for the quarter 1 April to 30 June 2025 were provided to the AIHW on 4 August 2025 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 care recipient 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).

Denominator data and QI construction

In accordance with the QI Program Manual, for all QIs except for Workforce, 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.

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

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

For the Workforce QI, 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.

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

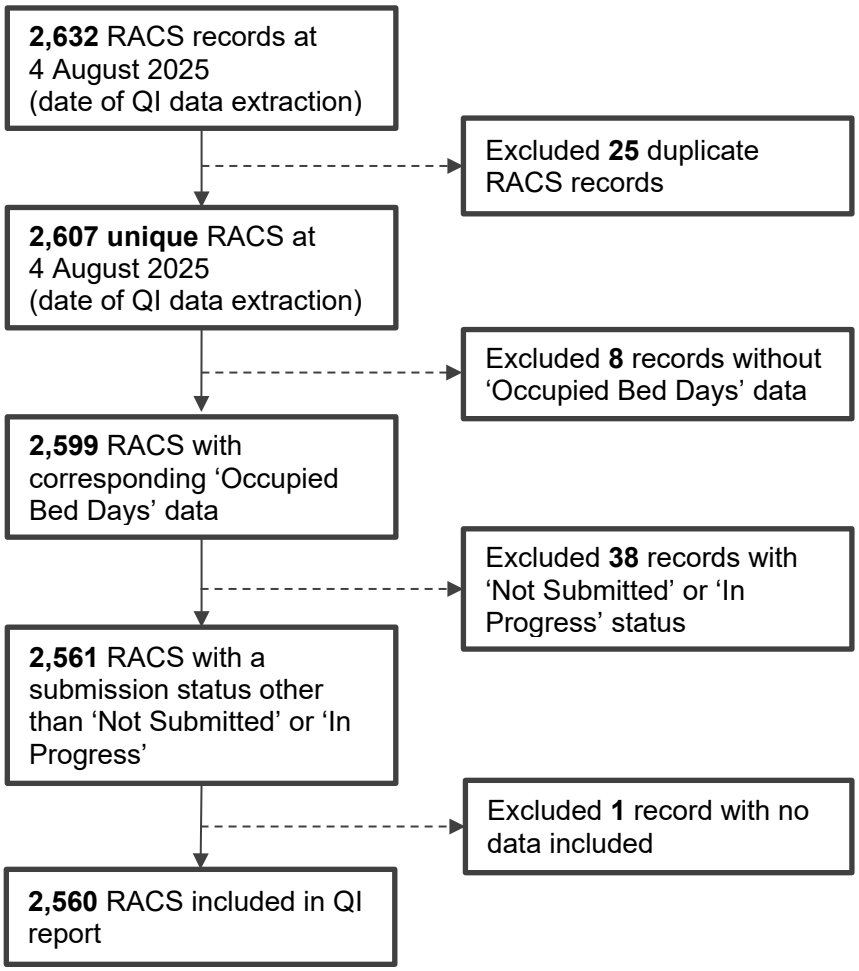
Service participation, and estimated care recipient coverage

For this quarter, providers were required to submit QI data to the Department by 21 July 2025. The QI raw data were then extracted by the Department on 4 August 2025, comprising data from 2,632 RACS records. Following the removal of 25 duplicate entries, a total of 2,607 unique RACS records were retained. The unique RACS records were then filtered using Occupied Bed Days (OBD) data to derive an approximate denominator. OBD data were extracted from the Quarterly Financial Report system by the Department on 4 August 2025 and supplied to the AIHW on 4 August 2025. Eight RACS were excluded due to not having available data about Australian Government subsidies for delivering care, services and accommodation (OBD data).

Of the remaining 2,599 RACS, 1,954 (75.2%) had a submission status of ‘Submitted’ (i.e., QI data were submitted on time), 598 (23.0 %) were ‘Submitted - Updated After Due Date’, 9 (0.4%) were recorded as a ‘Late submission’, 37 (1.4%) were recorded as ‘Not Submitted’ and 1 (~0.0%) had ‘In Progress’. The 38 RACS with a ‘Not Submitted’ or ‘In Progress’ status were excluded from the analyses presented in this quarterly report.

Finally, 1 (0.04%) of the remaining 2,561 RACS did not submit any QI data and was excluded, resulting in the final data set of 2,560 RACS with at least some QI data submitted. Compared with the previous quarter, this represents a decrease in RACS included in this quarterly report of 1.4%. Of the included 2,560 RACS, 2,534 (99.0%) submitted QI data for all 11 QIs detailed in this report, 25 (1.0%) submitted data for 9 or 10 QIs, and 1 (~0.0%) submitted data for 8 QIs.

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



The QI Program's coverage of the estimated care recipient population ranged from 99.1% for consumer experience to greater than 108.8% for falls and major injury (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 service in that period. While the numerator data for QIs measure one event per individual, 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 individuals occupied beds per quarter. This approximation assumes that individuals occupy beds for the same number of days per quarter, but this may not be the case.

There are various reasons an individual 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 individual 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 care recipients (e.g. hospitalisations) and care recipient 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 4 August 2025 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 care recipients excluded (Table S1, Columns C and D) was highest for consumer experience and quality of life (32.9% and 33.1%, respectively). For these QIs, the most common reason for exclusion was that the care recipient did not choose to complete the survey.

Table S1: Estimated care recipient coverage and exclusions in the RACS QI Program, April to June 2025

QI	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	209,883	103.4%	978 (0.5%)	379 (0.2%)	208,526 (99.4%)
Restrictive practices	204,675	100.8%	N.A.	2,168 (1.1%)	202,507 (98.9%)
Unplanned weight loss — significant	220,524	108.7%	4,508 (2.0%)	44,277 (20.1%)	171,739 (77.9%)
Unplanned weight loss — consecutive	219,958	108.4%	5,804 (2.6%)	46,470 (21.1%)	167,684 (76.2%)
Falls and major injury	220,862	108.8%	N.A.	377 (0.2%)	220,485 (99.8%)
Medication management — polypharmacy	202,585	99.8%	N.A.	1,410 (0.7%)	201,175 (99.3%)
Medication management — antipsychotics	202,710	99.9%	N.A.	768 (0.4%)	201,942 (99.6%)
Activities of daily living	218,530	107.7%	N.A.	29,115 (13.3%)	189,415 (86.7%)
Incontinence	209,632	103.3%	N.A.	504 (0.2%)	209,128 (99.8%)
Incontinence associated dermatitis	209,632	103.3%	N.A.	50,931 (24.3%)	158,701 (75.7%)
Hospitalisations	220,222	108.5%	N.A.	543 (0.2%)	219,679 (99.8%)
Workforce**	N.A.	N.A.	N.A.	N.A.	N.A.
Consumer experience	201,032	99.1%	63,299 (31.5%)	2,735 (1.4%)	134,998 (67.2%)
Quality of life	201,705	99.4%	64,118 (31.8%)	2,529 (1.3%)	135,058 (67.0%)

Notes:
* Included RACS 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. 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.
** It is not possible to calculate estimations of coverage for the Workforce QI because population data are not available.
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 (202,951) care recipients—calculated by summing the total number of 'Occupied Bed Days' (OBD) 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.
Source: Department of Health, Disability and Ageing, QI and OBD data extracted 4 August 2025, published on GEN-agedcaredata.gov.au

Geographic characteristics

Two separate disaggregations are reported for the location of RACS—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 service-level data from the National Aged Care Data Clearinghouse (NACDC) as at 30 June 2024 (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) service identification number, the identifier used in the NACDC. In this step, 2,542 of the 2,560 included records matched with a service identified in the NACDC. Eighteen records did not match with NACDC service 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 service populations. Caution should be exercised in interpreting and comparing QIs in states and territories where smaller populations mean fewer services, 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 Mandatory Quality Indicator Program Manual 4.0, which has been in place since 1 April 2025. Similar to the QI Program Manual 3.0 (in place since 1 April 2023), the QI Program Manual 4.0 counts the number of care recipients 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 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 RACS as aggregated data at the service 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 RACS represents an incorrect data point.

Some variation in the total number of care recipients assessed in a RACS 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 RACS 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 care recipients assessed or over-reporting of the number of care recipients 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 restrictive practices (0.5%). This is expected as some services that have reported 100% for restrictive practices are specialist dementia or mental health services within a locked facility. Therefore, all care recipients in these services 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 consumer experience (13.4%) (Table S2). Some RACS reported zero care recipients meeting the criteria for individual QIs, which varied between QIs (Table S2).

Table S2. Selected RACS reporting characteristics in the Mandatory QI Program, April to June 2025

QI	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	0	0.0%	283	11.1%
Restrictive practices	13	0.5%	352	13.8%
Significant unplanned weight loss	0	0.0%	245	9.6%
Consecutive unplanned weight loss	2	0.1%	232	9.1%
Falls	5	0.2%	7	0.3%
Falls that resulted in major injury	0	0.0%	881	34.4%
Polypharmacy	4	0.2%	4	0.2%
Antipsychotics	6	0.2%	22	0.9%
Activities of daily living	2	0.1%	118	4.6%
Incontinence associated dermatitis	1	0.0%	667	26.1%
Hospitalisations – Emergency department presentations	3	0.1%	163	6.4%
Hospitalisations – Emergency department presentations or hospital admissions	4	0.2%	44	1.7%
Workforce	4	0.2%	607	23.7%
Consumer experience	342	13.4%	1	0.0%
Quality of life	174	6.8%	6	0.2%

Note: Percentages are calculated in relation to 2,560 RACS
Source: Department of Health, Disability and Ageing, data extracted 4 August 2025, published on GEN-agedcaredata.gov.au

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 Q4 (April to June) 2024-25. 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 care recipients 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 care recipients assessed for QI *i* in quarter *j*.

Differences in numbers of care recipients assessed by each service are considered by including an **offset** in the model ($\log(n_{i,j})$) so that the care recipient count is adjusted to be comparable across services 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 care recipients 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 care recipients 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. service 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 services 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 care recipients meeting the criteria for the QI in each quarter
- the total number of care recipients assessed for the QI in each quarter summed over all services that submitted QI data.

References

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