LASA
LEADING AGE SERVICES AUSTRALIA
The voice of aged care

DEVELOPMENT OF RESIDENTIAL AGED CARE QUALITY INDICATORS

Submission, 9 December 2019

A strong voice and a helping hand for all providers of age services

Leading Age Services Australia

Leading Age Services Australia (LASA) is a national association for all providers of age services across residential care, home care and retirement living/seniors housing. Our purpose is to enable high performing, respected and sustainable age services that support older Australians to age well by providing care, support and accommodation with quality, safety and compassion – always.

LASA's membership base is made up of organisations providing care, support and services to older Australians. Our Members include private, not-for-profit, faith-based and government operated organisations providing age services across residential aged care, home care and retirement living. 55% of our Members are not-for-profit, 37% are for-profit providers and 8% of our Members are government providers. Our diverse membership base provides LASA with the ability to speak with credibility and authority on issues of importance to older Australians and the age services industry.

Introductory remarks

Thank you for the opportunity to provide feedback on the development of the National Quality Indicator Program (NQIP). LASA believes that effectively measuring the performance of age care services and the age services system as a whole is vital to improving quality of care and implementing broader policy reform.

Notwithstanding that, LASA does not believe that the NQIP is the most effective way to measure quality. The NQIP indicators are relatively narrow, not risk adjusted and costly to collect. The collection cost is important because often providers already collect similar information in ways that they have incorporated into their quality management systems, but must now consider whether to run those existing systems in parallel with NQIP or switch to a new system with which they are unfamiliar.

LASA strongly contends that the work being undertaken by Registry for Senior Australians (ROSA)[1] at the South Australian Health and Medical Research Institute which uses administrative data to measure quality should be the preferred approach to measuring clinical quality outcomes. The system developed by ROSA is risk adjusted, comes with little cost to providers to collect data and only a small cost to Government, and is less vulnerable to perverse incentives than self-collected data. Since it is based on administrative data new indicators can be added or adjustments can be made with relatively little cost. This approach to measuring clinical outcomes should be supplemented by other indicators of quality of life and broader system performance, which is another issue not addressed by the NQIP.

Focussing specifically on the consultation paper distributed, LASA conducted two teleconferences with Members over two consecutive days to gather feedback to the questions in the consultation paper *Development of Residential Aged Care Quality Indicators.*

Members observed as a positive that the NQIP had focussed their attention on components of their care performance they previously had paid less attention to. For example, one provider realised that bed rails were much more in use than previously thought. As a result a program of discussing the advantages and disadvantages of bedrails with residents and their relatives was undertaken. Relatives liked the bedrails and did not realise any of the disadvantages to resident safety involved in the use of these rails.

One provider reported that it was good to see their performance confirmed at the level where the provider had thought it would be.

However, concerns were expressed over incongruities in the National Aged Care Mandatory Quality Indicator Program Manual 1.0 which lead to differences in the interpretation of the information it contains. LASA Members consider the definitions given in Program Manual 1.0 not to provide sufficient guidance when applied to the Residential Aged Care Facility (RACF) care setting, causing much confusion and anxiety.

Another serious concern for LASA is that the consultation paper states on page 24:

[1] https://rosaresearch.org

> 'It is anticipated that, once the QI data has been established as valid and reliable, risk adjustment **may be considered.'** (emphasis added)

LASA reiterates that the risk adjustment of quality indicators is essential to the success of the NQIP. If the NQIP indicators are to truly represent a RACF's quality of care performance, then the indicators need to be adjusted to the profile of the RACF's resident mix. This is of particular importance for small, freestanding providers whose resident mix can skew their quality outcomes due to their low resident numbers. For example when LASA consulted, a Member who owns a small, freestanding RACF reported to have nine residents receiving palliative care, which amounted to almost 12 per cent of all residents. The high percentage of residents receiving palliative care may skew specific quality outcomes, such as pressure injuries. This could make the provider's performance look poor when in fact outcomes may be good or excellent considering the fairly large cohort of residents receiving palliative care.

Larger providers are more insulated from specific resident cohorts affecting overall quality outcomes as large numbers of residents act to dilute this effect. Thus the quality performance of providers with small resident numbers may be misrepresented by the NQIP and this adds a serious dimension of injustice to the program. LASA is concerned that the lack of risk adjustment resulting in (1) the potential misrepresentation of small providers' care performance and (2) making impossible a comparison of quality outcomes across RACFS will undermine providers' commitment to the NQIP. This would be a lamentable, missed opportunity to put well-working structures into place to support the quality performance of the residential aged care sector. LASA again observes that scientists at ROSA have been developing ways to risk adjust measures of quality outcomes in residential aged care and recommends that this work be taken advantage of. Associate Professor Maria Inacio is director of ROSA and can be contacted by email on maria.inacio@sahmri.com

LASA again suggests that the quality indicator program developed by ROSA be used. ROSA utilises administrative data, making outcome measures quite resistant to gaming and the indicators have been risk-adjusted. Further, they were developed in consultation with aged care providers and consumers. The NQIP could continue as a voluntary program for providers to monitor their individual performance alongside a national program of quality metrics developed by ROSA.

Comments to existing quality indicators

LASA is unable to respond to all 37 questions posed in the consultation paper. Our feedback will be specific to the current quality indicators and to those indicators considered for future inclusion in the NQIP. At the end of the submission further considerations about the program are included.

Pressure injuries

LASA Members expressed concern that it is difficult for providers to achieve consistent stageing of pressure injuries between different staff (interrater reliability). On a larger scale the issue of variation in stageing of pressure injuries between RACFs also arises, making NQIP outcome measures unreliable.

Members were divided about excluding Stage 1 pressure injuries from the NQIP. Stage 1 pressure injuries usually do not have long-term adverse effects on residents and some Members considered that they could be excluded for this reason. Other Members thought that knowing the rate of Stage 1 pressure injuries would give valuable information to providers whether measures undertaken to prevent pressure injuries are sufficient.

Physical restraint

Generally, this indicator was considered important as it focusses providers' effort on checking that any kind of restraint used is appropriate as a last resort and that all necessary consent is in place. However, the definition of what constitutes a physical restraint is unclear and causes much anxiety amongst providers. One Member related that a resident who wore an all-in-one garment to prevent him from undressing in public, causing disturbance and intimidation of fellow residents, was considered 'restrained' by the Aged Care Quality and Safety Commission. The issue of a bed pushed against a wall constituting restraint is still causing much confusion. As the definitions provide insufficient guidance, providers recount that they err on the side of caution, which may skew overall results.

LASA Members would like an email address where they can place questions about practical aspects of the NQIP and where they can learn from responses given to other providers. The restraint count is labour intensive and LASA Members are concerned about more time being taken away from care delivery. This is a not insignificant opportunity cost, particularly in view of the shortfalls of the NQIP discussed above.

Unplanned weight loss

Generally, this indicator was considered useful in gauging how the RACF is managing care. Members considered that the definition of 'unplanned weight loss' leaves open what weight loss is 'planned' and what is 'unplanned'. Members observed the resident mix to affect this indicator with high care residents being more prone to weight loss which may be because these residents are approaching the end of their lives. They also noted that changes in weight occur with the seasons, with weight tending up during winter and reducing in summer.

Falls with fracture

LASA Members believe that the results for this indicator should be presented with contextual information explaining contributing factors, such as the resident's appetite for risk. The number of falls with fracture and the number of residents who fall with fracture should be reported.

Medication management

LASA Members observed that most providers collect data on a wide selection on the proposed quality indicators to monitor medication management in their RACFs. LASA Members reported these to be:

- QI 1 Care recipients receiving nine or more medications
- QI 2 Care recipients who received antipsychotic medication
- QI 3 Care recipients who received anti-anxiety or hypnotic medication
- QI 4 Medication errors resulting in an adverse event requiring intervention
- QI 6 Care recipients using regular antipsychotic medicines
- QI 8 Total number of medication errors by service
- QI 9 Care recipients with more than 4 regular medication administration times
- QI 10 Percentage of care recipients on polypharmacy (10 or more)
- QI 12 No pharmacy review of medication

Members observed that they do not have control over medical doctors' prescribing practices and their willingness to review medications. In this sense the prescription and review related medication management indicators measure a quality performance that does not solely represent providers'

performance. However, an indicator checking the rate of medication reviews undertaken for residents at a RACF was considered to deliver important feedback.

Program considerations

Members expressed concern that, because many providers already collect the information sought for the NQIP, they now have to re-work existing data to fit new parameters. Members called for the NQIP to make use of what quality metrics are already undertaken in the sector in order that no more time is being taken away from caring for residents.

The NQIP data collection tools require customisation when they are being operationalised at the RACF level. Members are concerned how the Aged Care Quality and Safety Commission will evaluate the necessary adjustments made.

The portal for the upload of data is reported to make this task cumbersome. Another concern with the portal is providers' inability to access reports on the data submitted. One Member reported that the graph in the report received did not reflect the data submitted!

Members strongly supported that materials be made available to assist providers' efforts with quality improvement activities. They proposed that these materials should be fairly high level and not too prescriptive so providers can adapt to their specific setting.