

Resource manual for Quality Indicators in Public Sector Residential Aged Care Services

2007-2008 version 1



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for Quality Indicators in
Public Sector Residential Aged Care Services

2007 – 2008 version 1

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Resource manual Quality Indicators in Public Sector Aged Care Services – Resource Manual 2007-2008 version 1

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Glossary of terms and acronyms

ACHS	Australian Council on Healthcare Standards
ACSQHC	Australian Commission on Safety and Quality in Health Care previously the Australian Council for Safety and Quality in Health Care
AIMS	DHS Agency Information Management System
APAC	Australian Pharmaceutical Advisory Council
APMH	Aged Persons Mental Health unit
DHS	Victorian Government Department of Human Services
DON	Director of Nursing
Incidence	The occurrence of cases is generally at a specific time, a snap shot ¹
NUM	Nurse Unit Manager
Prevalence	The occurrence of cases over usually an extended period of time ²
PSRACS	Public Sector Residential Aged Care Services
PUPPS	Pressure Ulcer Point Prevalence Survey
QIC	Quality Improvement Council
<i>The Act</i>	The Aged Care Act 1997
The Agency	Aged Care Standards and Accreditation Agency
VQC	Victorian Quality Council
YTD	Year to date

¹ Nay et al, 2004, Public Sector Residential Aged Care Quality of Care Performance Indicator Project Report, *The Aged Care Branch of the Department of Human Services (Victoria)*, p 7

² IBID

Quality Indicators

The Australian Council of Healthcare Standards defines quality indicators for resident or patient care as:

measures or flags which can alert to possible problems and opportunities for improvement in patient care³

The purpose of the Public Sector Residential Aged Care Services (PSRACS) quality indicators project is to develop and introduce practical, meaningful measures – which will assist services and DHS to monitor and improve resident care.

Use of Indicators

The Aged Care Standards and Accreditation Agency (the Agency) advocates the use of data, including quality indicators, as follows:

data provides evidence about the standard of service in the aged care home or the efficiencies of processes⁴.

There is a wide range of potential uses and benefits of quality indicators. By measuring and analysing data, residential aged care services can show:

- targets or standards are being met
- services to residents are improving
- processes are working well
- improvements are occurring as planned
- improvements are sustained over time
- any changes that need to be made to policies and procedures
- any additional improvements that need to be made⁵.

It is important to recognise however, that the collection of data itself, serves little purpose unless it is properly collated, analysed and used to change or improve practice.

Quality indicators are tools or guides that support quality systems. They do not necessarily represent a direct measure of quality⁶.

Quality indicators can be used to improve practice at:

- an individual resident level, or at
- a systems or organisational level.

³ The Australian Council of Healthcare Standards, *What is the Performance and Outcomes Service*, <http://www.achs.org.au/> (accessed 7 March 2006)

⁴ Aged Care Standards and Accreditation Agency Ltd, 2004, *The benefits of using data and measurements*, Information sheet.

⁵ *ibid*

⁶ Nay et al, 2004, Public Sector Residential Aged Care Quality of Care Performance Indicator Project Report, *The Aged Care Branch of the Department of Human Services (Victoria)*, p 1, 2

The information and data that is collected for individual residents should be utilised as part of your ongoing assessment and care planning process for each resident.

The data collected and the results received from DHS can also help services to ascertain if changes need to be made to processes or systems, or if new processes need to be introduced.

The significance of a quality indicator can be more apparent and therefore yield greater insight, when the information is compared with other relevant data. For example:

- **internal comparison** - with other periods of time, other residents, etc.
- **external benchmarking** - comparison with data from other services or with industry standards.

Benchmarking

Quality Indicators allow a service to benchmark itself against other services.

“Benchmarking is simply about making comparisons with other organisations and then learning the lessons that those comparisons throw up⁷.”

Such comparison may be used to:

- monitor and assess performance
- identify examples of good practice - how and why different organisations do things similarly and differently
- identify areas for further examination.

It is important to promote benchmarking as part of a learning culture. The focus should be on identifying the processes and activities that enable the achievement of good practice - rather than focusing entirely on comparison of performance measures. It should provide the impetus for seeking new ways of doing things.

It is also important to ensure that:

- senior managers support benchmarking and are committed to continuous improvements
- stakeholders, including staff, are kept informed of the reasons for benchmarking and of the results
- staff are involved in undertaking benchmarking to make the most of the opportunities for learning from others, and involved in the development of realistic improvement recommendations.

⁷ The European Foundation for Quality Management, *The European Benchmarking Code of Conduct*, <http://www.efqm.org> (accessed 6 March 2006)

Introduction of Indicators for PSRACS

The purpose of the PSRACS Quality Indicators project is to develop and introduce practical, meaningful measures – which will assist services and DHS to monitor and improve resident care.

Development

Five Quality Indicators have been developed, trialled and refined; and have now been implemented across all PSRACS in Victoria.

Past studies and research identified that the highest incidence of harm typically occurs in a number of specific areas. These 'high incidence' areas include:

1. medication use - including over-use
2. falls – this is the leading cause of injury and death in people aged 65 and over
3. pressure ulcers⁸.

In addition, two further indicators have been developed for areas of specific concern in residential care:

4. the use of physical restraint
5. unplanned weight loss.

The focus of the development project has been on clarity and simplicity. Aspects of care that are difficult to define or measure are not included at this stage.

Implementation

The Quality Indicators were implemented from July 2006. 2006-07 was a transition year while services became familiar with the program, integrated it into their continuous improvement strategy and took the first steps in benchmarking.

Services should ensure that relevant information is disseminated within their organisation and that there is ongoing allocation of responsibility for the Quality Indicators program.

For the first 12 months of the program, services collected and reported the required data for each indicator to DHS. DHS reported back to each service on the prevalence and/or incidence of each indicator for their service. Services were also provided with averaged data for all services and data over time. Services were able to use the data and the results to identify where:

- Changes might need to be made to process or systems
- Improvements were occurring as planned
- Improvements were being sustained over time
- Additional improvements might need to be implemented.

Following this 12-month introduction period, there will be an increasing emphasis on public reporting and accountability. Services will have greater depth of data and benchmarking opportunities.

⁸ Office of the Safety and Quality Council, *Adverse events rates*, Fact sheet

Indicator 1: Prevalence of stage 1 – 4 pressure ulcers

Protocol sheet

Objective: To monitor prevalence of pressure ulcers and trends in this prevalence

Data collection:

- Collect data through an assessment of every resident once each quarter.
- The resident should be informed about the proposed assessment and their permission sought. If permission is withheld an entry should be made in *Comments*. (See *Information for resident's on page 29 to assist in this process.*)
- Data is to be collected by full body assessment of resident. Where possible this should be completed in conjunction with the resident's usual personal care.
- The survey can be conducted EITHER by assessing every resident over a set period of up to 14 days OR by identifying an assessment date for each resident and completing the assessment on the same day each quarter.
- **All** observed pressure ulcers are to be recorded.
- Ulcer stage is to be assessed using the *National Pressure Ulcer Advisory Panel (NPUAP) Pressure Ulcer Staging System, Victoria Quality Council (refer page 2)*. The staging system should be used consistently and for all residents surveyed.
- Any uncertainty about presence and stage of pressure ulcers should be addressed through consultation with a suitably qualified person.

Comments

- For residents admitted during the current reporting quarter, ulcers that were present on admission are to be included in the count and noted in *'Comments'*. In subsequent quarters, these ulcers are to be included in the ordinary count – no comment required.
- The above note also applies to respite residents.
- A comment should be included where the pressure ulcer developed while the resident was away from the PSRACS, for example, while in acute care or away on holiday.
- A comment should also be included where the pressure ulcer relates to a resident in end-stage palliative care.

Exclusions: Nil. **Do** include respite residents.

Definition of key data elements

- **A pressure ulcer** is defined as 'any lesion caused by unrelieved pressure, resulting in damage of the skin and underlying tissue'.

Source: *Australian Wound Management Association. Clinical Practice Guidelines for the Prediction and Prevention of Pressure Ulcers. 2001*

Alternate terms include 'bed sore' and 'decubitus ulcer'.

Pressure Ulcer Staging System

Stage 1 Pressure Ulcer

Observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area of the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching). The ulcer appears as a defined area of persistent redness in lightly pigmented skins, whereas in darker skin tones, the ulcer may appear with persistent red, blue or purple hues.

NB 1. Reactive hyperaemia (that is, skin discolouration) may easily be confused with a Stage 1 pressure ulcer. Reactive hyperaemia is a normal compensatory mechanism following an episode of reduced perfusion from localized pressure. Relief of this pressure results in a large and sudden increase in blood flow to the affected tissue.

NB For the purpose of this survey, patients who are identified as having an area of reactive hyperaemia will need to be repositioned off the affected area; the skin will then need to be re-inspected thirty minutes later for evidence of a Stage 1 pressure ulcer.

From Appendix B *National Pressure Ulcer Advisory Panel Staging System* in PUPPS 3 Report 2007, (see Resources list).

Stage 2 Pressure Ulcer

Partial thickness skin loss involving epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister or shallow crater.

Stage 3 Pressure Ulcer

Full thickness skin involving damage or necrosis of subcutaneous tissue that may extend down to but not through underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

Stage 4 Pressure Ulcer

Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures (for example, tendon or joint capsule). Undermining and sinus tracts may also be associated with Stage 4 pressure ulcers.

Source: *Australian Wound Management Association. Clinical Practice Guidelines for the Prediction and Prevention of Pressure Ulcers. 2001*

Resources and further information

There are a number of resources that have been developed specifically for health and/or residential services to introduce or manage pressure ulcers. There is also a range of courses available for staff in the management of wounds. The following resources and information are all available via the internet:

- Website of the Australian Wound Management Association - <http://www.awma.com.au>
- Pressure ulcer basics online education program - <http://www.health.vic.gov.au/pressureulcers/education.htm>
- VQC State-wide - Pressure ulcer point prevalence survey PUPPS 1 (2003), 2 (2004) and 3 (2007) Reports <http://www.health.vic.gov.au/pressureulcers/pupps.htm>
- Joanna Briggs Institute Best Practice information sheets 'Prevention of pressure related damage' and 'Management of Pressure related tissue damage' - www.ioannabriggs.edu.au/pubs/best_practice.php
- Queensland Health, 2004, Pressure Ulcer Prevention and Management - Resource Guide - http://www.health.qld.gov.au/quality/Publication/pressure_mgt2004.pdf

Data Recording Sheet

Name of service:	
Reporting quarter end date:	
Survey period or date:	

Table - Number and stage of pressure ulcers at survey

	Stage 1	Stage 2	Stage 3	Stage 4	Total
Number of pressure ulcers					

Comments:

- Required if applicable - **Only for residents admitted in this quarter** - note any pressure ulcers reported above that have been present since admission
For example, 1 x stage 4 and 1x stage 3 present on admission
- Required if applicable - Number pressure ulcers reported above that developed while the resident was away from the PSRACS, for example, in hospital or on holiday
For example, 1 x stage 2 ulcer developed while resident away on holiday/in hospital
- Required if applicable - Number pressure ulcers reported above that relate to residents in end-stage palliative care
For example, 3 x stage 2 and 1 x stage 3 relate to people in end-stage palliative care
- Optional – any other relevant comments

Indicator 2: Prevalence of falls and fall-related fractures

Protocol sheet

Objective: To monitor prevalence of falls and fall-related fractures and trends in this prevalence.

Data collection:

- Collect data through a quarterly audit of resident records and incident reports.
- If a resident is found on the floor or ground, it should be assumed that they have fallen (unless they are cognitively unimpaired and indicate that they put themselves there on purpose).
- If a fall resulted in more than one fracture, all fractures are to be recorded.

Comments

- Include comments where number of falls or fractures is heavily influenced by one or two individuals or by a specific incident.

Exclusions: Falls and fractures that occur while resident is away from RAC facility AND is not under direct supervision of RAC staff.

Do include respite residents

Definition of key data elements:

- **A fall** is an event that results in a person coming to rest inadvertently on the ground or floor or other lower level.
Source: World Health Organisation and used for Safety and Quality Council guidelines for preventing falls and harm from falls in older people.
- **A fracture** is traumatic injury to a bone in which the continuity of the bone tissue is broken.
Source: Mosby's Medical Nursing & Allied Health Dictionary (6th edition) 2002

Resources and further information

A range of resources is available to assist health and residential services to introduce and manage a falls prevention program or to reduce the harm related to falls and to the fear of falling. The following resources and information are available via the internet:

- Australian Council on Safety and Quality in Health Care, especially 'Preventing falls and harm from falls in older people. Best practice guidelines for Australian hospitals and residential aged care facilities' and associated resources.
www.safetyandquality.org
- Victorian Falls Prevention Program
www.health.vic.gov.au/agedcare/maintaining/falls/index.htm
- Victorian Quality Council
www.health.vic.gov.au/qualitycouncil
- National Falls Prevention for Older People Initiative
www.health.gov.au
- National Ageing Research Institute
www.nari.unimelb.edu.au

Data recording sheet

Name of service:	
Reporting quarter end date:	
Audit Date:	

Table: Falls and fall-related fractures

Total number of falls	Number of fractures resulting from falls

Comments:

- **REQUIRED if applicable** - Comment where number of falls or fractures is heavily influenced by one or two individuals or a specific incident
For example, 1 resident fell 13 times with 2 fractures, 5 fractures from one fall down a staircase.
- **OPTIONAL** – any other comments

Indicator 3: Incidence of use of physical restraint

Protocol sheet

Objective: To monitor the incidence of use of physical restraints and trends in this incidence

Data collection:

- Identify three audit days in the quarter. On each of these audit days, conduct three audits of all residents, (one during the morning, one in the afternoon and one during the night). This is a total of 9 observation audits over the quarter.
- Observation audits should be unannounced.
- **Part A - All** uses of physical restraint **as per Definition** are to be recorded. This includes restraints listed in Part B **IF** these restraints also meet the **Definition**.
- **Part B – All** the physical restraints **defined in List B** are to be counted.
- If a resident is restrained by more than one type of restraint, each restraint is to be counted. This applies to Part A and Part B.
- In order to further develop the information from this indicator it is recommended that services begin recording the total number of people who are restrained at ANY of the audits and including this number in comments. The next review of this collection will determine whether this additional data will be added to the AIMS reported data.

Please refer to **Appendix 2** for further information and guidance on this indicator.

Comments:

- Indicate the number of uses of restraint in the total that were specifically requested by the resident and/or their family or advocate. This comment is to be included for both parts of this indicator.
- **New information** - Indicate the total number of residents who were restrained at any of the audits. This comment applies only to part A.

Exclusions: Locked wards and perimeter alarms **are not** included for the purpose of this indicator **HOWEVER**, restraining (for example, locking) an individual in their room **IS** counted.

Do include respite residents.

Definition of key data elements:

Part A

- **Physical restraint** is defined as "The intentional restriction of a resident's voluntary movement or behaviour by the use of a device, or removal of mobility aids, or physical force for behavioural purposes is physical restraint.

Physical restraint devices include **but are not limited to** lap belts, tabletops, posey restraints or similar products, bed rails, and chairs that are difficult to get out of such as beanbags, waterchairs and deep chairs."

Source: Decision making tool: Responding to issues of restraint in aged care
Department of Health & Ageing, 2004
www.health.gov.au/internet/wcms/publishing.nsf/Content/ageing-decision-restraint.htm

Part B

List B

- Bedrails
- Chairs with locked tables
- Shackles
- Manacles
- Seat belts other than those used during active transport
- Safety vest

Notes

Collection methods and requirements	<p>The data is to be collected through an unannounced observation audit. The timing of the audit should remain undisclosed to staff, except for the person conducting the observation.</p> <p>Ideally audits should be performed by staff who are not involved in the direct care of the residents on that day.</p> <p>The person conducting the audit should directly observe all residents at the allocated time. The person should walk through the facility and record any uses of restraint.</p> <p>In larger organisations the observations can be made by managers as they perform routine 'rounds' or by quality staff during the day and by 'supervisors' at night.</p> <p>For some smaller facilities, the only staff present onsite at night are direct care staff. Alerting a staff member that they are to conduct an audit related to restraint may result in altered practice and therefore influence the count.</p> <p>An alternative may be for managers to contact staff working at night at a certain time (previously undisclosed) and request that a staff member conduct the audit at that time. This approach may reduce the possibility of altered work practices.</p>
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	<p>The staff who conduct the audit should have a good understanding of the definition of restraint.</p> <p>To assist the facility in your quality improvement activities, additional data to that required for reporting to DHS, may be collected. Such useful additional information includes:</p> <ul style="list-style-type: none"> ▪ Resident identification ▪ Type of restraint used ▪ Whether there was appropriate documentation to support use of restraint. <p>Individual facilities should use a data collection sheet to suit their organisation. A sample data collection sheet is provided at Appendix 1.</p>
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Services should analyse the data collected for submission to DHS, and the results reported by DHS:

- What does this tell services about individual residents?
- What does this tell services about their overall systems and processes?

Any use of physical restraint should be investigated at the time of the audit. The resources listed below will assist you with other possible scenarios.

Resources and further information

The following resources and information are available via the internet:

- Decision making tool: Responding to issues of restraint in aged care
www.health.gov.au/internet/wcms/publishing.nsf/Content/ageing-decision-restraint.htm
- Joanna Briggs Institute – Best Practice Information Sheets. Physical Restraint Part 1 (2002 Vol 6 Issue 3) and Physical Restraint Part 2 (2002 Vol 6 Issue 4)
http://www.joannabriggs.edu.au/pubs/best_practice.php

Data Recording Sheet

Name of service:	
Reporting quarter end date:	
Dates of report days:	<ol style="list-style-type: none"> 1. 2. 3.

Table A: Number of uses of all physical restraint as per Part A definition

	Observation Day 1	Observation Day 2	Observation Day 3	Total
Total number of uses of physical restraint as per definition A from three observation audits on each observation day				

Comments

- REQUIRED if applicable - Number of the restraint uses in this Total that were specifically requested by the resident or the resident’s family/advocate for example, 12 restraint uses from total were water chair requested by family
- REQUIRED if applicable - **New information** - Indicate the total number of residents who were restrained at any of the audits.
- OPTIONAL – any other comments

Table B: Number of uses of List B physical restraint observed

	Observation Day 1	Observation Day 2	Observation Day 3	Total
Total number of uses of physical restraint as per list B from three observation audits on each observation day				

Comments

- REQUIRED if applicable - Number of the restraint uses in this Total that were specifically requested by the resident or the resident’s family/advocate for example, 3 restraint uses were bedrail requested by resident for security
- OPTIONAL – any other comments

Indicator 4: Incidence of residents using nine or more different medicines

Protocol sheet

Objective: To monitor incidence of residents using nine or more different medicines and trends in this incidence.

Data collection:

- Collect data through a quarterly audit of resident medication charts and/or administration records.
- Audit is to be conducted one nominated week within the quarter. This should then be repeated at 3 monthly intervals.
- Each different medication is to be counted.

Exclusions:

- Lotions/creams/ointments used in wound care
- Dietary supplements (see definition below) including those containing vitamins
- Alcohol (even if it is written up on medication chart)
- Short-term medications, e.g. antibiotics, temporary eyedrops
- PRN medications (NB if PRN medications are being used regularly they should be reviewed by the prescriber)
- **Do** include respite residents

Definition of key data elements:

- **Medicine** is defined as a chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease or otherwise enhancing the physical or mental welfare of people. It includes prescription and non-prescription medicines, including complementary health care products, irrespective of the administered route.

Source: *Guiding principles to achieve continuity in medication management July 2005. Australian Pharmaceutical Advisory Council*

- **Dietary supplement** is defined as a chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease or otherwise enhancing the physical or mental welfare of people. It includes prescription and non-prescription medicines, including complementary health care products, irrespective of the administered route.

Source: *Food standards code Australia and New Zealand – Standard 2.9.3*

Notes

Collection methods and requirements	<p>Data should be collected through an audit of each resident's medication administration chart and/or record.</p> <p>Count each different medicine that is ordered. Note that there are a number of exclusions (see below).</p> <p>Care should be taken to ensure that different doses or dosages of the same medicine are not counted as being different medicines.</p> <p>Medicines can be administered by a number of different routes. Each medicine should be counted once, regardless of the route of administration, for example,</p> <ul style="list-style-type: none">• orally• nasally• ocular• aurally• inhalation• intramuscular• intravenously• subcutaneously• dermally (patches)• rectally, and• vaginally. <p>The audit should be conducted by a member of staff who has an understanding of the definition of a medicine and can interpret the medication administration chart and/or record for any exclusions.</p>
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Where the audit for this indicator identifies residents using nine or more medicines this provides a trigger for further investigation to decide whether some level of medication review for this person is timely.

The resources listed below will assist you with other possible scenarios.

Resources

- Guidelines for Medication Management in Residential Aged Care Facilities
<http://www.health.gov.au/internet/wcms/publishing.nsf/content/nmp-pdf-resguide-cnt.htm>
- Residential medication management review
<http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-epc-dmmrqa.htm>
- Quality Use of Medicines
<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/nmp-quality.htm-copy2>

Data Recording Sheet

Name of service:	
Reporting quarter end date:	
Audit Date:	

Table: Number of residents using 9 or more medicines

Number of residents whose charts were audited	Number of residents using nine or more different medicines

Comments

- OPTIONAL – any comments

Indicator 5: Prevalence of unplanned weight loss

Protocol Sheet

Objective: To monitor prevalence of unplanned weight loss and trends in this prevalence.

Data collection:

- Collect data by auditing the monthly weight records of all residents.
- If over the three month period a resident shows a significant unplanned weight loss (see definition) then this change is to be recorded. This result is determined by comparing weight at the last weigh this quarter with weight at the last weigh last quarter. Both these weights need to be available to provide this result.
- In addition, if a resident shows an unplanned weight loss of any amount **every** month over the three consecutive months of the quarter, this is to be recorded. This can only be determined if the resident is weighed on all three occasions.

Comments:

- Explain why any residents were not included, ie where there is a difference between your total residents and the Number of residents whose weight was monitored.
- Indicate if any residents were included in both parts of the indicator, ie they lost 3kg or more AND lost weight every month for 3 months.

- Exclusions:**
- Resident absence, for example, in hospital
 - Resident in end-stage palliative care
 - Respite residents

Definition of key data elements:

- **Significant weight loss** is defined as weight loss equal to or greater than 3 kilograms over a three-month period
- **Unplanned weight loss** is weight loss where there is no written strategy and ongoing record relating to planned weight loss for the individual resident.

Notes

Collection methods and requirements	<p>Facilities do not need to weigh all residents on a single day. Rather, services can weigh a number of people on each day of the month. For example, if your facility has 40 residents and there are 20 weekdays in a month, you may decide to weigh 2 residents each day.</p> <p>Each resident, however, must be weighed at monthly intervals, i.e. as close as possible to the same day of each month.</p> <p>Only residents who are included in all three weighs for the quarter can be evaluated against this indicator.</p> <p>Residents may choose not to participate in this audit. This can be indicated in 'Comments'.</p> <p>Residents should not be weighed if this causes them pain or distress. Alternative equipment may be available to address this issue.</p> <p>Where a resident cannot be weighed they should be monitored by an alternative means such as mid-arm or calf circumference.</p>
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Resources and further information

An individual resident's unplanned weight loss should be investigated promptly and strategies put in place to address this concern as quickly as possible. The resources listed below will assist in this process.

A range of resources is available to assist health and residential services to manage nutrition within a residential aged care facility. The following resources and information are available via the internet:

- Well for Life – Improving nutrition and physical activity for residents of aged care facilities
www.health.vic.gov.au/agedcare/maintaining/index.htm
- Dietary Guidelines for Older Australians
www.nhmrc.gov.au/publications/synopses/n23syn.htm
- Identifying and planning assistance for home-based adults who are nutritionally at risk
www.health.vic.gov.au/hacc/publications/nutrisk-rm.htm

Data Recording Sheet

Name of service:	
Reporting quarter end date:	

Table: Number of residents who experienced unplanned weight loss

Number of residents whose weight was monitored	Number of residents who experienced a significant total unplanned weight loss (ie equal to or greater than 3 kg)

Number of residents whose weight was monitored	Number of residents who experienced an unplanned weight loss over three consecutive months

Comments:

- **REQUIRED** if applicable - Explain any difference between total residents and number of residents whose weight was monitored
for example, 2 residents died, 1 in hospital on 2 weigh day
- **REQUIRED** if applicable - Indicate number of residents who appeared in both parts of the indicator, ie they lost more than 3kg and lost weight for 3 consecutive months
for example, 4 residents lost more than 3kg AND lost weight every month
- **OPTIONAL** – any other comments

Information for residents

Your aged care home is one of nearly 200 homes operated within the Victorian State Health system. The Victorian Government, and the managers and staff at your home, are continually looking at ways to improve services to residents.

A recent initiative, to help check and improve services, is called the *quality indicators project*. This requires each home to collect certain information about the health of its residents, and regularly report this to the government.

This information reported to government does not include the name or any personal details of individual residents.

What information will be collected and reported?

Aged care homes will collect and report information related to the following five areas:

1. pressure ulcers, also known as pressure sores or bed sores
2. falls by residents, and broken bones arising from falls
3. physical restraint of residents
4. the number of medicines residents use
5. unplanned loss of weight by residents.

Residents' personal details will not be part of the information reported to government. For example, homes will report the number of residents who have lost weight, not their names.

How will this affect me as a resident?

The information collected will help staff and management to continuously check and improve the care you receive. It will also help the government to check that your aged care home is properly addressing the needs of all residents.

The collection processes will have little effect on residents, although you may notice staff doing some additional checking and review of the care you receive. Some things you may notice are:

- Each resident will undergo a physical assessment once every three months, to collect information about bed sores. This assessment will be conducted by your normal care staff during your routine hygiene activities. Staff will request your permission before conducting the assessment.
- Care staff will ask if you have any areas of discomfort where you have been sitting or lying - and will have a close look at your skin for any areas of redness or breaks. Staff will document any areas they find. These questions and this type of assessment are a normal part of your daily routine and that of your care staff. However a different staff member may need to be involved - who has special training in pressure sores.
- All residents will be weighed monthly. Most residents are however already weighed regularly as part of their normal routine.

Remember - it is part of the normal routine of care staff to keep an eye on and assess residents on a regular basis, to ensure they are well and healthy. Staff at your aged care home, regularly check and assess you. Most of the information required to be reported to government, will be collected as part of this normal routine.

Please speak to a staff member if you have any concerns or questions.

Summary data for entering on AIMS

NB Person completing this sheet – please ensure that any comments from your Data Recording Sheet are included for each indicator.

NB Person entering data on AIMS – please ensure that all comments provided are entered on AIMS.

Indicator 1 - Number and stage of pressure ulcers at survey

	Stage 1	Stage 2	Stage 3	Stage 4	Total
Number of pressure ulcers					

Comments: transfer comments from Data Recording Sheet

Indicator 2 - Falls and fall-related fractures

Total number of falls	Number of fractures resulting from falls

Comments: transfer comments from Data Recording Sheet

Indicator 3 – Use of physical restraint

Part A	Total
Total number of uses of physical restraint as per definition A from three observation audits on each observation day	

Comments: transfer comments from Data Recording Sheet

Part B	Total
Total number of uses of physical restraint as per list B from three observation audits on each observation day	

Comments: transfer comments from Data Recording Sheet

Indicator 4 - Number of residents using 9 or more medicines

Number of residents surveyed	Number of residents using nine or more different medicines

Comment: transfer comments from Data Recording Sheet

Indicator 5 - Number of residents who experienced unplanned weight loss

Number of residents whose weight was monitored	Number of residents who experienced a significant total unplanned weight loss (ie equal to or greater than 3 kg)

Number of residents whose weight was monitored	Number of residents who experienced an unplanned weight loss over three consecutive months

Comments: *transfer comments from Data Recording Sheet*

Entering data on AIMS

Quality Indicator data is entered quarterly on the Agency Information Management System (AIMS). It is due to be entered by 21st of the month following the end of the quarter, ie 21 October, 21 January, 21 April, and 21 July

Please note that ALL the following steps are needed to successfully submit data.

To enter your Quality Indicator data on AIMS:

- 1 Log onto the DHS Healthcollect Website. <https://www.healthcollect.vic.gov.au/>
- 2 Type in your User ID and Password and click on the 'Logon' key
- 3 Select Online Data Entry Public 2007
- 4 Select Quarterly Residential Forms
- 5 Select PRSACS: Residential Aged Care Services Quality Indicators
- 6 Select your service and the required Nursing Home/Hostel.
- 7 Make a selection from the drop down list of quarters.
- 8 Click on the 'Get Form' key.
- 9 Enter your data against the specific indicators. Use the Tab key to move through the data items. Remember to enter data in ALL required boxes and add comments where necessary.
- 10 When data entry is finished click on the 'Calculate' key
- 11 Click on the 'Validate' key and respond to any comments
- 12 If your data is final tick the 'Completed' box.
- 13 Save your data by clicking on the Save button.
- 14 If you wish to keep a hard copy of your data as entered - print a copy by pressing the 'Print' key on the top left of the data entry page and then pressing the printer logo at the top of the next screen.
- 15 Finally – 'Submit' your data to DHS by clicking on the submit button.

To see and print out a summary of your Quality Indicator data:

- 1 Select the Hospital Reporting folder
- 2 Select Hospital Activity Reports for the relevant year
- 3 Select YTD Public Sector Residential Aged Care Services
- 4 Select the Nursing Home/Hostel you wish to report on. You will then be able to view and print a summary of your data.

Appendix 1 – Sample data collection for Indicator 3 – use of physical restraint

Quarter ending: / / 20.....

Date Audit day 1: / / 20	1st audit	2nd audit	3rd audit	TOTAL
Time				
Conducted by				
<i>Total restraints that meet definition (Part A)</i>				Box 1
Number of <i>Total restraints that meet definition</i> that are requested by resident				Box 7
Number of <i>Total restraints that meet definition</i> that are requested by family				Box 10
<i>Total restraints that are in List B</i>				Box 4
Number of <i>Total restraints that are in List B</i> that are requested by resident				Box 13
Number of <i>Total restraints that meet definition</i> that are requested by family				Box 16
Date Audit day 2: / / 20	1st audit	2nd audit	3rd audit	TOTAL
Time				
Conducted by				
<i>Total restraints that meet definition (Part A)</i>				Box 2
Number of <i>Total restraints that meet definition</i> that are requested by resident				Box 8
Number of <i>Total restraints that meet definition</i> that are requested by family				Box 11
<i>Total restraints that are in List B</i>				Box 5
Number of <i>Total restraints that are in List B</i> that are requested by resident				Box 14
Number of <i>Total restraints that meet definition</i> that are requested by family				Box 17
Date Audit day 3: / / 20	1st audit	2nd audit	3rd audit	TOTAL
Time				
Conducted by				
<i>Total restraints that meet definition (Part A)</i>				Box 3
Number of <i>Total restraints that meet definition</i> that are requested by resident				Box 9
Number of <i>Total restraints that meet definition</i> that are requested by family				Box 12
<i>Total restraints that are in List B</i>				Box 6
Number of <i>Total restraints that are in List B</i> that are requested by resident				Box 15
Number of <i>Total restraints that meet definition</i> that are requested by family				Box 18

- For the new comment (Indicate the total number of residents who were restrained at any of the audits) a list of the people restrained at any audit will also be required. Any people not previously on this list for the relevant quarter will need to be added at each audit and the total people on the list counted for the new comment.

Tables for Data Reporting Sheet

Table A: Number of uses of all physical restraint as per Part A definition

	Observation Day 1	Observation Day 2	Observation Day 3	Total for all 3 observation days
Total number of uses of physical restraint as per definition A from three observation audits on each observation day	<i>From Box 1</i>	<i>From Box 2</i>	<i>From Box 3</i>	<i>Box 1 + 2 + 3</i>

Comments

- REQUIRED if applicable - Number of the restraint uses in this Total that were specifically requested by the resident or the resident's family/advocate.

Add boxes 7, 8, 9 for requests by resident.

Add boxes 10, 11, 12 for requests by family/advocate

- REQUIRED if applicable - **New information** - Indicate the total number of residents who were restrained at any of the audits.
- OPTIONAL – any other comments

Table B: Number of uses of List B physical restraint observed

	Observation Day 1	Observation Day 2	Observation Day 3	Total for all 3 observation days
Total number of uses of physical restraint as per list B from three observation audits on each observation day	<i>From Box 4</i>	<i>From Box 5</i>	<i>From Box 6</i>	<i>Box 4 + 5 + 6</i>

Comments

- REQUIRED if applicable - Number of the restraint uses in this Total that were specifically requested by the resident or the resident's family/

Add boxes 13, 14, 15 for requests by resident.

Add boxes 16, 17, 18 for requests by family/advocate

- OPTIONAL – any other comments

Appendix 2 – Guidance note for Indicator 3 – use of physical restraint

This Guidance Note is provided for use by the person conducting the physical restraint audit and for staff information, possibly during a discussion session or for incorporating in a handout.

All PSRACS should also have policy and procedures on restraint use which should be reviewed regularly to ensure that they are in line with good practice and funding and accreditation requirements.

Aged persons mental health residential services will also have a reporting requirement under the *Mental Health Act 1986* for mechanical restraint. The requirements for reporting can be accessed through the Chief Psychiatrist's Guideline at www.health.vic.gov.au/mentalhealth/cpg/restraint.htm

Remember the Indicator is not a **measure** of performance; it is an indication that there may be an issue or problem that should be addressed – it is a reminder or an alert to look at the issue and address the results.

Definitions

Restraint is any aversive practice, device or action that interferes with a resident's ability to make a decision or which restricts their free movement.

Definition A

Physical restraint is defined as "The intentional restriction of a resident's voluntary movement or behaviour by the use of a device, or removal of mobility aids, or physical force for behavioural purposes is physical restraint.

Physical restraint devices include **but are not limited to** lap belts, tabletops, posey restraints or similar products, bed rails, and chairs that are difficult to get out of such as beanbags, waterchairs and deep chairs."

Source: Decision making tool: Responding to issues of restraint in aged care Department of Health & Ageing, 2004 Part A

Source: Decision making tool: Responding to issues of restraint in aged care
Department of Health & Ageing, 2004
www.health.gov.au/internet/wcms/publishing.nsf/Content/ageing-decision-restraint.htm

Staff should refer to this Decision-making tool for additional information and guidance around issues of restraint in aged care. The tool also includes a list of Resources for further information and education.

List B

- Bedrails
- Chairs with locked tables
- Shackles

- Manacles
- Seat belts other than those used during active transport
- Safety vest.

The above list does not include all possible physical restraints. The audit process should consider whether placement of furniture, use of concave mattresses, lap rugs with ties or any other devices are actually being used with the intention of restraint.

FAQs

If a physical restraint that stops resident's voluntary movement is being used to prevent a resident falling, or some other hazardous situation, should this be counted for this indicator?

Yes. If the device or action restricts a resident's voluntary movement it counts as restraint.

If there are questions about a resident's capacity for voluntary movement or behaviour, due to cognitive issues, should their physical restraint still be counted in this audit?

Yes.

If an item that is normally classified as a 'restraint' is being used at the request of the resident or family/advocate, should this be counted as restraint in this audit?

Yes. If the item meets Definition A it should be counted in Indicator 3 Part A. If it is on List B it should be counted in Indicator 3 Part B. If it meets the definition AND is on List B it should be counted in Part A AND Part B.

A comment should be included to indicate number of use of restraints that were at request of the resident and number at the request of family/advocate.

Do all concave mattresses and water chairs count as restraint?

No. Concave mattresses and water chairs should only be counted if they meet Definition A, that is, if they restrict the resident's voluntary movement. This also applies to other items such as recliner chairs, deep chairs, bean bags etc.

If the resident is unable to move in any case, or if the movement being prevented is involuntary, or if the resident still has freedom of movement despite the item being in place, then the item does not meet the definition.

NB Any items that are on List B still need to be counted in Part B even if they do not meet the Definition in Part A.

If seatbelts are being used while people are being showered in shower chairs, do these count as restraint?

For Part A – If the seatbelt is used to intentionally restrict a resident's voluntary movement or behaviour, and the patient is not being actively transported, it should be counted.

Part B - If the patient is not being actively transported, seatbelt should be counted.

Tables for Data Reporting Sheet

Number of residents whose weight was monitored	Number of residents who experienced a significant total unplanned weight loss (ie equal to or greater than 3 kg)
Number of residents where there is (at least) a record of a weight carried forward and in the last month of the quarter	Total number of "Yes" in column 10
Number of residents whose weight was monitored	Number of residents who experienced an unplanned weight loss over three consecutive months
Number of residents where there is a weight carried forward and a weight for every month this quarter	Total number of "Yes" in column 11