QPS BENCHMARKING RESIDENTIAL AGED CARE

PERFORMANCE REPORT 2020

QPS benchmarking

Welcome.

As the Principal of QPS Benchmarking, it gives me great pleasure to present the QPS Benchmarking Residential Aged Care Performance Report.

Sharing our findings is important in continuously improving care and services to aged care consumers and for the dedicated providers delivering these care and services.

Utilising high-level collaborative skills, QPS Benchmarking has consulted to international and national organisations such as SAI Global's Business Excellence Framework, MBF Australia, IAHS and ACHS in the benchmarking and quality domains.

This ensured robust data collection and management in order to support the aged care industry to continually improve its performance. The contents of this report supports Approved Providers in meeting this goal.

I would also like to acknowledge the efforts and thank everyone who has been involved in the development of this report. Particularly I would like to thank the service providers, employees and consumers that contributed to the data used to inform this report.

Silvia Holcroft

PRINCIPAL QPS BENCHMARKING

RN, Diploma of Science
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Graduate Certificate Business Excellence
Certificate IV Organisational Assessment
Accident and Emergency Certificate.

Purpose of the Report

The residential aged care sector in Australia has undergone unprecedented change in the past two (2) years

The rate and the amount of legislative and regulatory change has created challenges for residential aged care homes as they face revised mandated expectations from the Commonwealth Government, and in turn consumers.

QPS Benchmarking has seen various iterations of residential aged care accreditation and funding models during its 22 year history.

QPS is an internationally recognised benchmarking service with a user base drawn from both the for profit and the not for profit residential aged care providers.

Offering a comprehensive suite of clinical indicators, survey and audit tools, QPS Benchmarking has amassed valuable data to inform current and future policy and practice.

This report presents the lived clinical journey of many thousands of consumers and the employees who deliver care and services between 2017 and 2019.

It is powerful data that cannot be ignored if safe and quality care is the true focus of the consumer journey.

CONTENTS

EXECUTIVE SUMMARY AND RECOMMENDATIONS

This report presents a unique review of the clinical governance of residential aged care in Australia between 2017 and 2019. It focuses on the lived experience of consumers, looking at residential aged care through the consumer's lens, the lens of those who provide the care and the care itself. The report's findings have far reaching policy and planning implications for the industry.

Key Findings

Trust in residential aged care by consumers is lacking. This must be restored. Key findings to support this are outlined below, divided into two critical elements - Leadership and Governance, and Clinical Workforce.

Leadership and Governance

1. Quality leadership is lacking across residential aged care
2. Industry leaders of the future must be agile, inclusive, focused, responsive and able to navigate complex systems
3. Generally, there is a disconnect between management and employees, however, consumers generally hold a positive attitude to front line care staff
4. Investment in education is imperative, particularly in the area of high impact clinical risk to ensure safe and quality care and services
5. The external regulatory environment imposes clinical standards for the workforce
6. Business fluidity is dependent upon targeted recruitment to meet the demands of Consumer Directed Care
7. Renewed rigour in governance is required
8. There is a need for nationally consistent clinical performance information, such as the data provided by QPS Benchmarking (Quality Performance Systems)

Clinical Workforce

1. The external policy dynamic and the internal workforce are the key drivers for the delivery of safe and quality care and service delivery systems in residential aged care
2. Employees are the foundation of residential aged care delivery in Australia
3. A skilled and sustainable workforce is needed to support a meaningful consumer journey
4. Clinical outcomes rely upon workforce capacity
5. All clinical outcomes must be informed by an evidence base
6. A culturally safe and competent workforce is needed to future proof care and service provision
7. Cultural change within residential aged care is critical for a future-oriented and change-ready workforce
8. Robust clinical competency assessments are needed

Recommendations

1. Whole of business governance

a. Support risk management through the use of validated benchmarking tools and risk assessment tools to protect business from civil and compliance issues, which will have an impact on the whole of business

b. Clear articulation of Organisational and Clinical Governance Frameworks for efficacy for the whole of business

2. Enhance consumer facing employee capability

a. Increase the minimum entry level qualification to a Certificate IV qualification for care employees

b. Establish a national register for care employees

c. Realign tertiary nurse education programs to better suit the needs of the sector

d. Support the Australian College of Nursing to provide scholarships to the residential aged care sector

e. Improve the flexibility and appropriateness of Vocational Education Training (VET)

f. Implement ongoing professional education requirements for care employees

g. Investment in talent acquisition is essential

h. Mandate education for all staff using a High Impact Risk Assessment Tool (such as HiRA-E)

3. Support for Employee Relations

a. Enhance Employee Assistance Programs to mitigate negative workplace cultures

b. Realign Enterprise Bargaining Agreements and other industrial award tools to the realities of residential aged care delivery, including competitive remuneration

c. Invest in meaningful Employee Reward Programs to encourage brand loyalty and cultural change based on organisational values

d. Invest in industry retention and attractor strategies, such as accelerated leadership programs based on merit and new graduate programs

4. Leadership

a. A focus on strategic leadership based on the needs and rights of consumers

b. Educational investment is needed in order to navigate a complex and dynamic regulatory environment

c. Clear career pathways and succession planning is required to sure up strategic leadership

d. Leadership that connects human rights, consumer values and resources is needed

e. Develop strategies to meet the anticipated need for increases in employee numbers over the next decade

f. Investment in targeted accredited education for leadership is pivotal for a change in culture and future-proofing the industry (for example, Graduate Certificate level programs offered through The Australian College of Nursing and Anchor Excellence development programs)

g. Provide education to existing leaders, through programs such as AnchorMentor

h. Remove the pressure on managers for short-term gains at the cost of strategic planning for ongoing sustained improvement

5. Clinical Experience

a. Reinforce the role of QPS Benchmarking (Quality Performance Systems) in continuous quality improvement or reengineering of clinical governance for compliance

b. Enhance access to evidence-based clinical practice information

c. Ramp up clinical competence assessments aligned to The Aged Care Quality Standards*

d. Develop clinical career pathways that are appropriately remunerated

e. Craft blended education opportunities based on education needs analyses

6. The Consumer

a. Leverage the positivity expressed by consumers towards front-line staff, further building trust and mutual respect

b. Continue to build a collaborative approach to clinical care

c. Operationalise an integrated partner in codesign model of care and services planning

d. Align consumer expectation and possible care and services outcomes with the realism of care and services provision

**Australian Government 2019*

Section One

About This Report

This independent report was commissioned by QPS Benchmarking, an internationally recognised quality benchmarking organisation.

The report was independently researched and written by The Anchor Excellence Research Team, led by Professor Irene Stein.

The Anchor Excellence Research Team membership includes:

- **Dr Irene Stein**
- **Cynthia Payne**

ABOUT QPS BENCHMARKING AND ANCHOR EXCELLENCE

QPS Benchmarking is a specialist aged care benchmarking organisation with over 20 years' experience in:

- Developing data-driven enablement software and tools
- Data analysis methodologies
- Contemporary indices for data collection
- Reflecting best evidence-based practice
- Clinical care modelling
- Clinical innovation and process redesign
- Meta-analysis of current best-practice trends
- Reflecting the legislative and regulatory aged care sector requirements in the audit tools.

Anchor Excellence is an aged care specialist consulting group that:

- Specialises in corporate and clinical governance solutions
- Provides expert support to implement new systems and processes for regulatory compliance
- Provides executive support to leadership at Board and senior leadership levels
- Provides specialist targeted education in the area of high impact clinical risk
- Operates within collaborative professional affiliate networks

Structure of Report

This report presents a snapshot of care and service provision in residential aged care in Australia between 2017 and 2019.

The report is based on data drawn from the QPS Benchmarking proprietary data in the area of consumer experience, workforce experience, and clinical experience.

Who should read this report?

This report is relevant for:

- Approved providers
- Regulators
- Consumers and their Nominated Representatives
- Clinicians
- Related health services, such as Local Health Districts, Residential Aged Care Liaison Nurses, and The Community Visitors Scheme
- Suppliers
- External service providers/contractors

Methodology

De-identified aggregated demographic, quantitative and qualitative data provided the information to inform this report.

An audit of the following QPS Benchmarking surveys was carried out in the following areas:

- The Consumer Experience - through the Resident Experience Survey and the Relative Experience Survey
- The Workforce Experience - through the Employee Satisfaction Survey
- The Care Experience - through the Clinical Indicators, Quality of Care and Clinical Care audits.

Explaining the Consumer and Workforce Data

Quantitative data captured demographic information and performance-based information using a Likert Scale. Qualitative data was gathered through the use of open-ended questions.

Clinical care and service provision data was gathered through a series of audits in identified domains and aligned to the national QPS Benchmarks and the National Quality Indicator Program*.

Key themes and data correlation were identified, forming the basis for recommendations and improvements.

The QPS Benchmarking Methodology

Dr Shaw, a QPS Benchmarking statistician, developed the framework for reporting, based on statistically valid principles. The QPS Industry Benchmark is derived by calculating the weighted mean.

It follows two key principles:

Normalization Process - Benchmarking with normalization allows effective comparison across variables and the QPS Benchmarking software is based on standard deviations, identifying variations and outliers. The normalisation process also takes into account the properties of each indicator and appropriate formulas are applied.

Each indicator has a defined Numerator and Denominator, evidenced based criterion and data collection tools.

The Validation Process - The QPS Benchmarking data cleansing process has 3 steps and includes specifically developed algorithms in the software to identify errors in individual data. A rigorous examination of all data is also performed at the site and the industry wide levels.

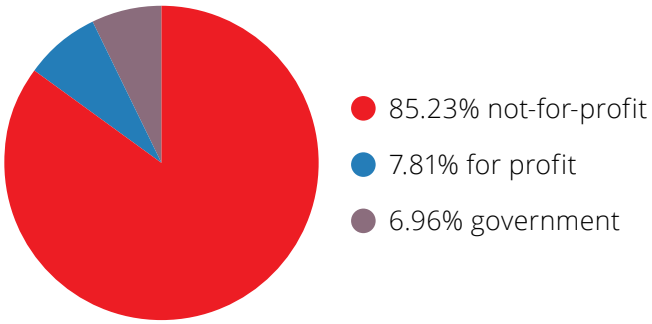
The Participants

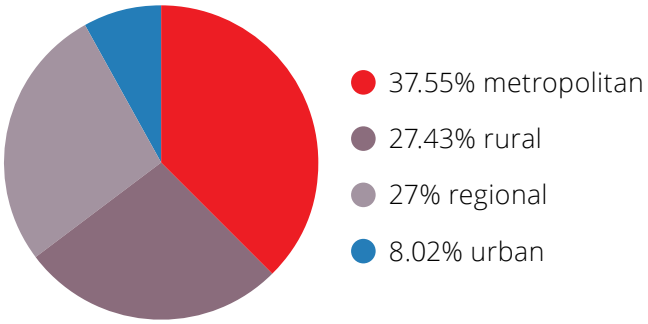
Participants were drawn from the not-for-profit, for-profit and government sectors of residential aged care. 85.23% of participants were from the not-for-profit sector, 7.81% for profit and 6.96% government.

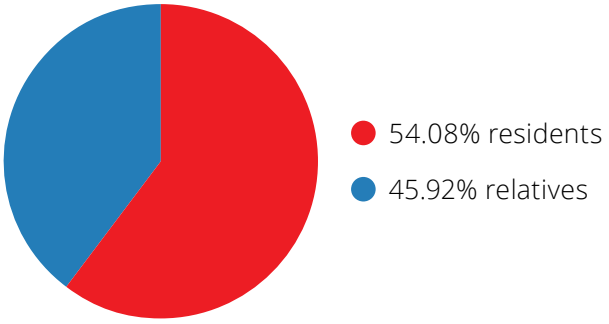
474 aged care residential homes in metropolitan, urban, regional and rural areas of Australia participated in the data collection. 37.55% of participants were drawn from metropolitan areas, 27.43% rural, 27% regional and 8.02% urban.

The total number of survey participants was 13,714 residents and 11,645 relatives.

The total number of employee participants was 19,655.







*Australian Government 2019,
Royal Commission into Aged Care Quality and Safety 2019

Residential Aged Care in Australia

The residential aged care system in Australia has been described by the Royal Commission into Aged Care Quality and Safety* as "a broken system that fails to meet the needs of older vulnerable people."

It is a system that faces many current and future challenges as it comes to terms with this situation. These challenges are driven by both external and internal stressors.

The external stressors include:

- The Royal Commission into Aged Care Quality and Safety*
- Multiple changes in regulatory and compliance structures and powers, in particular, those of The Aged Care Quality and Safety Commission*
- Negative and sustained media attention
- Funding levels ill aligned to real costs
- Diminishing pool of quality applicants for senior positions within organisations

The internal stressors include:

- The changing expectations of the consumer and the Nominated Representatives
- Hypervigilance and surveillance of process and practice by the consumer and the Nominated Representative
- Existing and entrenched workforce cultures
- Inexperienced management reluctant to tackle hard issues
- Inability to attract workforce that will enhance capability
- Existing workforce capability that cannot meet the care and service needs due to the increased acuity of consumers
- Increasing level of staff turnover
- Poor wage growth

Sustained long term change is needed to address these stressors.

"A broken system that fails to meet needs of older vulnerable people."

– The Royal Commission into Aged Care Quality and Safety*

*Aged Care Quality and Safety Commission 2019
Royal Commission into Aged Care Quality and Safety 2019*

Section Two

The Consumer Experience

The data collected reflecting the consumer experience was sourced from the QPS Benchmarking surveys, undertaken between 2017 and 2019. The number of participants was 13,714 residents and 11,645 relatives.

In this context the 'consumer' means the resident receiving care and services and/or their Nominated Representative.

The surveys used were:

- The QPS Benchmarking Resident Experience Survey
- The QPS Benchmarking Relative Experience Survey

These consumer experiential surveys are mapped to:

- Aged Care Quality Standards*
- Aged Care Quality Standards* Consumer Outcomes
- Aged Care Quality Standards* Organisation Statements
- Aged Care Quality Standards* Requirements
- Aged Care Quality Standards* Guidance and Resources for Providers

The QPS Benchmarking Consumer Experience Surveys focus on:

- The consumer's experience and choice
- The systems and processes that underpin this experience
- Feedback systems to improve safe and quality care and services delivery
- Informing continuous improvement processes

These foci collect consumer-facing data that aligns with the Aged Care Quality Standards*.

The Residential care sector performance data for July-September 2019 identifies personnel number/ sufficiency as the second most frequent complaint concerning residential care, accounting for 15% of complaints received by the Aged Care Quality and Safety Commission*.

The data presented in this report reflects this trend.

*Australian Government 2019
Aged Care Quality and Safety Commission 2019

Mapping of the Aged Care Quality Standards* and QPS Benchmarking Survey domains

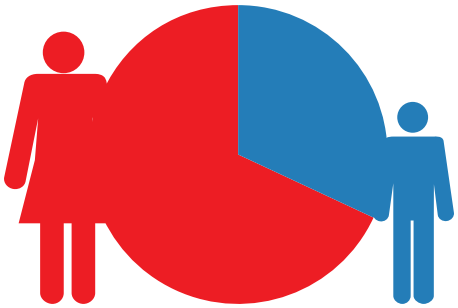
AGED CARE QUALITY STANDARDS*	QPS SURVEY DOMAIN
Consumer dignity and choice	Choice and Respect Culture and Lifestyle Independence
Ongoing assessment and planning with consumers	Assessments and Care Planning
Personal care and clinical care	Care and Service Delivery Medical and Therapy Services
Services and supports for daily living	Meals and Dining Cleaning and Laundry
Organisation's service environment	Your Accommodation and Living Areas General Living Accommodation - (outside my bedroom)
Feedback and complaints	Complaints and Feedback
Human resources	Knowledgeable, Capable and Caring Staff
Organisational governance	Wellbeing and Overall Satisfaction

*Australian Government 2019

THE PARTICIPANTS

Gender

- 68% Female
- 32% Male



Age

The median age is 85-89 years.

There has been a downward trend in the number of admissions of people aged under 65 years. This is in line with the partial roll-out of the National Disability Insurance Scheme, which funds alternative accommodation relating to the in-house care options for younger people with disabilities, who formerly had no other accommodation options.

Length of Residence

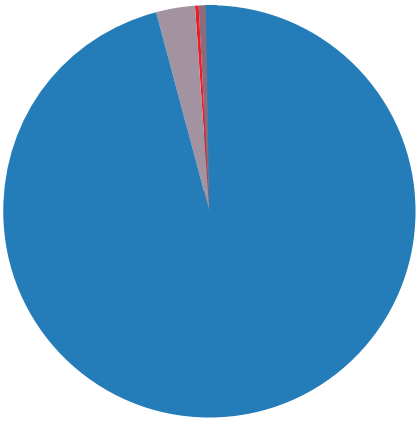
The median length of residence is 1-2 years.

The greatest turnover of residents is amongst participants who have lived in the home for less than 12 months.

This indicates the impact of respondents receiving community care packages, enabling them to choose to remain at home longer; and seeking admission only when their care needs are unable to be met in that environment.

Linguistic groups

- 95% English
- 3% Asian language groups (Vietnamese, Cantonese and Mandarin)
- 0.4% Arabic
- 0.7% European language groups (Italian, Greek, Polish and German)



The largest increase is within the Asian speaking respondents, in particular those from a Vietnamese background.

Decreases were identified in the European language group, in particular those speaking Greek and Spanish.

Though small in number, the respondents from Culturally And Linguistically Diverse (CALD) backgrounds inform:

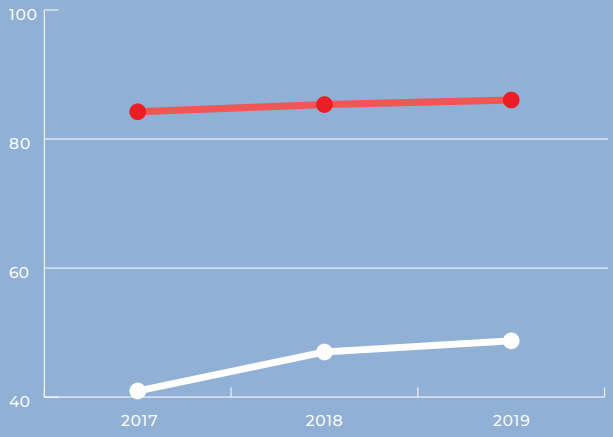
- Need for culturally appropriate assessments and care and services planning
- Need for staff from these CALD
- Need for cultural sensitivity education for all levels of staff
- Recognition of the role of partners in care

NET PROMOTER SCORE®

The Consumer Net Promoter Score® (NPS®) is a metric used to measure consumer loyalty and to indicate the consumer's satisfaction with the care and services they are receiving.

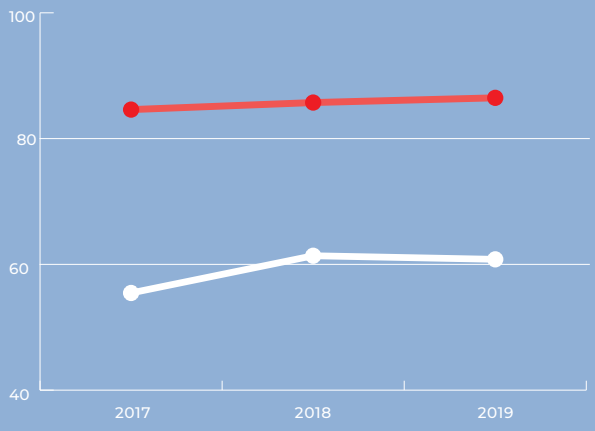
Net Promoter, Net Promoter Score® and NPS® are registered trademarks of Bain & Company, Inc., Satmetrix Systems, Inc., and Fred Reichheld.

Net Promoter Score® and The Resident Experience Index



Survey Year	Net Promoter Score®	Resident Experience Index
2017	+40.94 (41)	84.23 (84)
2018	+46.99 (47)	85.35 (85)
2019	+48.72 (49)	86.05 (86)

Net Promoter Score® and The Relative Experience Index



Survey Year	Net Promoter Score®	Relative Experience Index
2017	+55.45 (55)	84.61 (85)
2018	+61.37 (61)	85.73 (86)
2019	+60.80 (61)	86.48 (86)

**Note - In the context of scoring, the NPS® is scored between -100 to 100. For this reason, these scores align with the Resident and Relative Experience Index. The NPS® has increased or remained stable over this period of time.*

WHAT THE CONSUMERS TOLD US

The following trends and findings are taken from the 13,714 residents and 11,645 relatives surveyed.

Survey Domains

1. Choices and Respect

Respondents identified front-line staff:

- Provided choice
- Demonstrated respect
- Carried out their work in challenging circumstances

This has improved between 2017-2019.

Verbatim comments identified approachable and dedicated staff who listened to their requests and acknowledged lifestyle choices.

Not all verbatim comments were positive with respondents describing the workforce as inadequate for the workload, leading to rushed and disrespectful interactions.

Management was viewed as unapproachable and disconnected. Overall low staff morale was attributed to poor leadership.

The built environment limited choice and lacked private space for consumers.

2. Culture and Lifestyle

Whilst there was improvement in this domain, the provision of culture and lifestyle support relied on the quality of the activity's programs. These programs were identified as:

- Limited in range and choice
- Lacking gender specificity
- Not available in the evenings or on weekends
- Lacking in intellectual stimulation
- Having very limited outdoor opportunities
- Having an over reliance on TV

Respondents did however feel that there was choice with regards to their participation.

Although positive comments were made about the quality of the leisure and lifestyle staff, verbatim comments reflected:

- Bored residents
- Insufficient qualified staff
- A lack of support from management for the leisure and lifestyle program
- A need for activities that catered for bed-bound residents or residents with continuous oxygen
- Suggestions for more outings and bus trips
- Frequent program changes and cancellations

3. Independence

Between 2017 and 2019 there was a marked improvement in staff encouraging and supporting residents to make their own decisions about their care and services. Verbatim comments indicated it was workforce dependent with some staff supporting independence, whilst others did not.

There was encouragement for:

- Social connectedness through IT contact with family and friends
- Maintaining former social networks outside the home
- Open visiting for family and friends

Workforce issues that impacted independence were identified as:

- A lack of ongoing feedback to the consumer or Nominated Representative in relation to changes in ability levels
- Poor English language skill levels of staff, leading to a lack of understanding of capacity levels

4. Assessments and Care Planning

Respondents indicated they were involved in their care and services assessments, receiving explanations from staff, as well as plan outlines.

However, there was overall dissatisfaction with medication management in the home and with external pharmacy service provision.

Respondents identified that:

- There is limited discussion by the Medical Officer (MO) and staff about reasons for changes in medications
- There was no encouragement to self-medicate
- Medications are missed (not given) by staff
- Poor external pharmacy arrangements are in place

Respondents also identified that high staff turnover and shift shortfalls resulted in a lack of continuity of care.

The infrequent nature of case conferences was also identified as impinging on assessments and care planning.

5. Care and Service Delivery

Respondents were satisfied with the care and services they received, and had trust in staff to deliver these care and services.

Verbatim comments supported these findings with respondents identifying good care and service delivery, and the support to meet care related challenges.

Conversely, respondents reported that the care and services they receive is workforce dependent:

- More staff is needed, with less reliance on agency staff who do not know the consumer
- More registered nurses with specialist knowledge and skills are needed
- The quality of care depends on staff mix on the day
- There are long call-bells response times
- Care and Services plans are not implemented
- Medical Officers' requests are not followed up
- Staff mix does not promote a feeling of safety

In the area of medication management, security and reliability of the supply process was a concern.

6. Medical and Therapy Services

Respondents indicated access to medical services had declined since 2018, and the verbatim commentary supported these findings.

Respondents wanted:

- More frequent access to their medical officers, with longer consultation periods
- More information concerning their medication regimens and a more reliable pharmacy service
- Improved access to dentistry, optometry, podiatry and audiometry

Workforce issues were also identified:

- High staff turnover
- Insufficient staffing levels
- Inexperienced staff

7. Meals and Dining

There was general dissatisfaction with meals and dining. The majority of respondents found meal times an unpleasant experience.

Verbatim comments expanded these themes about the food:

- Meals were cold, boring and repetitive
- Food was unpalatable and unappetising, with an absence of vegetables
- Choice was limited with items removed from the menu without notice.

The dining experience was viewed as:

- Stressful due to the inability of staff to manage challenging behaviours
- Noisy with loud background music not suited to the consumer
- Crowded and uncomfortable
- Lacking stimulation

Overall meal service times were unsatisfactory with comments such as:

- Meals crammed into a short time period between 08:00-17:00
- Hunger was experienced after 17:30
- Inappropriately loud levels of music in the dining room
- Encouraged to eat evening meals in their rooms off a tray

There was also dissatisfaction concerning the support times for assistance with meals by staff members. This again resulted in cold, unappetising food. Respondents reported missing cutlery from meal trays and delays in attracting staff attention to have these replaced.

Staff also served foods that had been expressly identified as inappropriate for religious and cultural reasons, such as pork and beef.

There was no socialisation encouraged after the evening meal. Activity programs were not offered to residents wishing to remain out of bed following their evening meal.

The verbatim commentary concerning resident choice not to eat in the dining room supported the general findings concerning the dining experience. Their choice was based on:

- The excessive noise levels
- Lack of sociality
- Having nothing in common with other residents

Other reasons included:

- Exercising own choice
- Valuing their own space
- Desire for privacy

The desire for privacy was based on embarrassment due to:

- Dysphagia and coughing when eating, causing unpleasantness for other residents
- Facial changes as they did not wear their dentures when eating
- Reduced hand eye coordination

Other respondents reported wanting to eat their evening meal in their rooms so they could watch their favourite TV shows and eat with their spouse/partner.

Other respondents were bedbound.

These are significant findings as unexpected and unplanned weight loss is a high risk lead clinical indicator*.

8. Cleaning and laundry

There was a degree of satisfaction with the standard of home cleanliness and hygiene. However, some verbatim comments included malodours, a need for spot cleaning of chairs and soft furnishings, and more dusting.

There was overall dissatisfaction with the laundry services.

Verbatim comments included:

- Clothing in poor condition and damaged on return from laundry
- Items of clothing are lost
- Residents' clothes are incorrectly returned to other residents
- Turnaround times lengthy
- Clothes that require ironing are not ironed

Respondents indicated that family members take their laundry home to avoid these issues.

Rationale for these comments include:

- Industrial washing machines not domestic washing machines are used
- Laundry staffing levels cannot absorb ironing of

*Australian Government Department of Health 2019 Anchor Excellence 2019, National Quality Indicator Program

clothes

- Use of clothes dryers
- Insufficient amounts of clothing for residents provided
- No weekend laundry service
- Labels come off over time
- External contractors used, making it difficult to track missing items in a timely manner
- Insufficient modern laundry equipment

9. Your Accommodation and Living Areas

Both positive and negative commentary was received.

The positives:

- Environmental controls for heating and cooling
- Access to bathrooms and toilets

The negatives:

- Lack of privacy
- High noise levels, especially staff related at night
- Long call-bell response times leaving consumers in soiled clothing
- Poor lighting

The reasons:

- Excessive noise late in the evening and at night, especially from staff members
- Loud radio and TV in the common areas
- Staff do not provide adequate personal privacy for personal care or knock on the door before entering rooms
- Inadequate staffing levels

10. General Living Accommodation Outside My Bedroom

Positivity was expressed about the accessibility and ease of movement around the areas outside of the resident's bedroom. Residents also stated there was general improvement in the common relaxation areas. This is reflected in improvements in the domain benchmarking, particularly in the comfort and relaxation areas.

Conversely, other respondents described common areas as:

- Malodorous
- Dominated by loud TVs and radios
- Small for the purpose with trip hazards, such as chairs and trolleys
- Lacking quiet spaces

Outdoor areas were described as:

- Poorly presented and maintained with broken and dirty furniture
- Uneven pathway gradients in outdoor areas
- Limited in size and functionality
- Doors difficult to open
- Restricted access of an evening and on weekends

Outdoor areas in new builds were described as having good amenity.

11. Complaints and Feedback

The positive feedback reflects the improvements in this domain. Comments include:

- A feeling of safety in relation to being able to make comments and complaints
- Some staff are helpful, responsive and approachable
- Consumer meetings were a positive experience
- There is a desire to resolve issues before any complaints are formalised

The negatives fell into two categories - the workforce and management.

Workforce issues were reported by respondents as a concern, specifically:

- Poor information transfer between shifts
- Inadequate staffing levels to deliver care, especially on weekends
- Inadequate kitchen staff to ensure meals are delivered on time and hot
- Inadequately trained staff to provide specialist care
- High staff turnover that prevents a relationship of trust being developed

Management issues include:

- Non-responsive to complaints and feedback
- Long delays in the complaint resolution process
- Unapproachable management
- Not always truthful when asked about staffing levels

Respondents also reported:

- Satisfaction with Resident/Relative Meetings
- Approachable and caring staff
- Desire by staff to sort out any issues before they are formalised
- Poor response from management when a written feedback form is submitted

12. Knowledgeable, Capable and Caring Staff

The respondents in this domain identified caring staff who are supportive, helpful, open to suggestions and responsive.

This is in an environment where respondents described the workforce as:

- Busy and rushed with limited time to spend with individual residents
- Experiencing ongoing staff shortages
- Having high staff turnover
- Employing inexperienced staff requiring more training
- Having rostering practices that limit meaningful relationships with staff

Management were noted as:

- Being non-responsive regarding staffing
- Engaging in ineffective rostering practices
- Not rostering for acuity
- Not fostering clinical handover skills to enable continuity of care
- Not supporting the activities program
- Being over reliant on agency staff usage

13. Wellbeing and Overall Satisfaction

Respondents attributed their overall well-being and satisfaction levels to caring, kind, respectful and friendly staff. This was counterbalanced by frontline staff that were rushed and not always able to provide care and services based on best practice.

Some respondents described management as:

- Non-responsive to wellbeing concerns
- Contributing to poor staff morale
- Not knowing each resident personally
- Engaging in care limiting rostering practices

It was also noted that challenging behaviours that were not managed by staff caused concern for consumers.

Suggestions for improvements included:

- Provide escorts for external appointments
- Provide more qualified staff
- Sitting outside after lock up at 5pm would be enjoyable
- Provide more outings
- Make it feel more like home

Respondents were then asked, 'how likely they would be to recommend the home to family and friends?'

The home promoters (scoring 9-10) identified the following attributes in support of the scoring:

- Welcoming, safe and friendly
- Good communication
- Adequate staffing
- Approachable management
- Good reputation
- Homelike
- Enjoyable activities
- Good meals
- Good general amenity

Passive respondents (scoring 7-8) identified the following in support of the scoring:

- Having kind staff
- Having high staff turnover
- Having poor information transfer between consumers and staff
- Providing tasteless meals
- Comfortable and safe
- Open visiting
- Long buzzer response times
- Satisfactory
- Providing tasteless meals
- Lack of privacy
- Lock up at 5pm
- Not well treated by staff

Detractors who responded scored between 0-6. They identified the following in support of the scoring:

- Institutional
- Understaffed
- Staff with poor interpersonal skills
- Staff with poor English skills
- Poor complaint and feedback management
- Poor food
- Compressed meal times
- No access to shops or money
- Noisy environment
- Noisy call-bells
- No café
- Lonely
- No weekend or evening activities
- Poor outside amenity

"The recurring theme despite the scoring was that respondents would rather be at their own personal home, regardless of the amenity of the residential home or their own adjustment to living at the home."

Respondents were then asked what they disliked about the home. Responses fell into three categories - workforce, management and general amenity.

Workforce:

- Inadequate and time poor
- Having poor English skills
- Not communicating incidents and transfers to another service
- Unmotivated
- No consumer directed care
- Disrespectful
- Engaging in open conflict with each other

Management:

- Invisible
- Unable to manage staff
- Unable to manage complaints
- Ignoring difficult situations such as resident abuse
- Inconsistent rostering

General amenity

- Not homelike
- Noisy
- Poor meal choice and quality
- Malodorous
- Lacking privacy
- Inadequate and inaccessible outdoor areas
- Unreliable laundry service
- Poor cleaning
- Restricted activity programs

Respondents were then asked what they liked about the home. Responses fell across the same three categories.

Workforce

- Hard-working and caring
- Professional and engaged
- Courteous and respectful
- Approachable
- Values driven
- Good communication
- Good activities and outings

Management

- Accessible
- Responsive
- Open attitudes
- Positive consumer meetings

General amenity

- Clean and bright
- Feeling safe and secure
- Calm
- Coffee shop
- Good grounds
- Lots of space to move around
- Well maintained

Summary

This consumer facing data describes an environment whose effectiveness is reliant on three key factors:

1. **Workforce**
2. **Management**
3. **The built environment**

The successful application and delivery of these components is critical to inform the effectiveness of care and services provision.

Across all domains these factors have been identified as key drivers of safe and quality practice to mitigate high impact clinical risk.

Section Three

The Employee Experience

The QPS Benchmarking Employee Satisfaction Survey yields annual demographic, quantitative and qualitative data about the current aged care workforce. As such it presents a comprehensive overview of employee sentiment in relation to their working environment.

The sample was based on 19,655 employees working in residential aged care homes who responded to the QPS Benchmarking Employee Satisfaction Survey, with 65% front-line care staff.

EMPLOYEE SATISFACTION SURVEY

Survey Approach

Surveys are conducted on-line or using a paper-based methodology. A web-based link is provided to the QPS survey to directly capture the ratings and verbatim comments from the employees. The results are then compared against the QPS Benchmarking Residential Aged Care industry benchmarks.

The Net Promoter Score® (NPS®) is a part of the QPS Benchmarking Employee Survey.

The NPS® is a validated and credible metric that is globally recognised to measure employee loyalty. The NPS® is a proven, powerful indicator designed to measure the willingness of employees to recommend the organisation as a great place to work and is a lead indicator for staff retention.

Net Promoter®, Net Promoter Score® and NPS® are registered trademarks of Bain & Company, Inc., Satmetrix Systems, Inc., and Fred Reichheld.

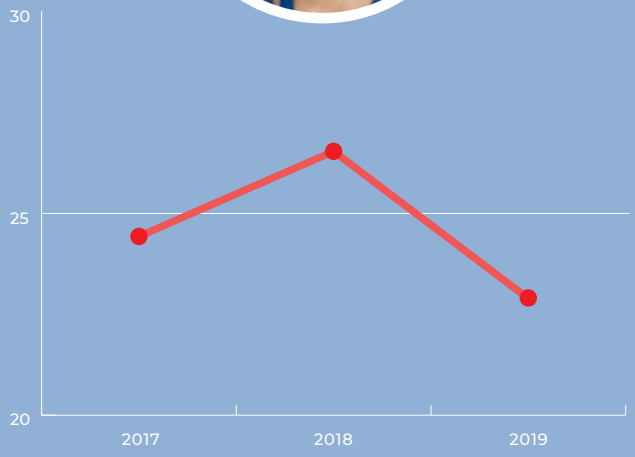
Scoring for the NPS® ranges between -100 to +100.

Purpose Of This Survey

The purpose of the QPS Employee Satisfaction Survey is to identify:

- Employee commitment and longevity
- Improve organisational performance
- Build relationships between the employee and the organisation

Net Promoter Score®



Survey Year	Net Promoter Score®
2017	+24.43
2018	+26.54
2019	+22.89

Alignment to the Aged Care Quality Standards and requirements*

The QPS Benchmarking Employee Satisfaction Survey is aligned to the following Aged Care Quality Standards and requirements*:

AGED CARE QUALITY STANDARDS*	STANDARD 7 HUMAN RESOURCES STANDARD 8 ORGANISATIONAL GOVERNANCE
Requirements	**Standard 7 (3) (a, b, c, d, & e)** **Standard 8 (3) (a, b, c,)**
Organisation Statements	**The requirements for the above Standards set out the following expectations:** **7 (2) The organisation has a workforce that is sufficient, and is skilled and qualified to provide safe, respectful and quality care and services** **8 (2) The organisation's governing body is accountable for the delivery of safe and quality care and services**

*Australian Government 2019
Aged Care Quality and Safety Commission 2019

Employee Profile

This report presents deidentified aggregated employee data from the QPS Benchmarking Employee Satisfaction Survey Results (2017-2019) located in metropolitan, urban, regional and rural areas of Australia.

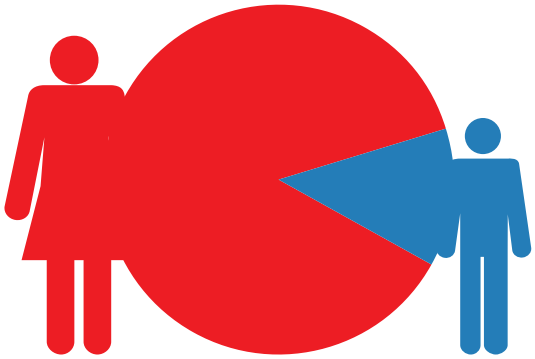
19,655 employees responded.

The Employee Satisfaction Index has remained stable between 2017 and 2019 aggregated at 81.83%.

Demographics

Gender of Workforce

Residential aged care is predominately female. This is reflected in the participants with:



- 87% Female
- 13% Male

Employment Type

Key trends:

- Decrease in full time staff
- Increase in part time staff
- Increase in casual staff

There has been no significant change in the use of agency staff.

Workforce Profile

Key trends:

- 4% decline in care staff between 2017 and 2019
- The numbers of management and catering staff reflected a modest increase in numbers by 2%
- Significant growth of 8% in General Service staff
- There was no change in the levels of administrative or therapy and activity staff

Age

Key trends:

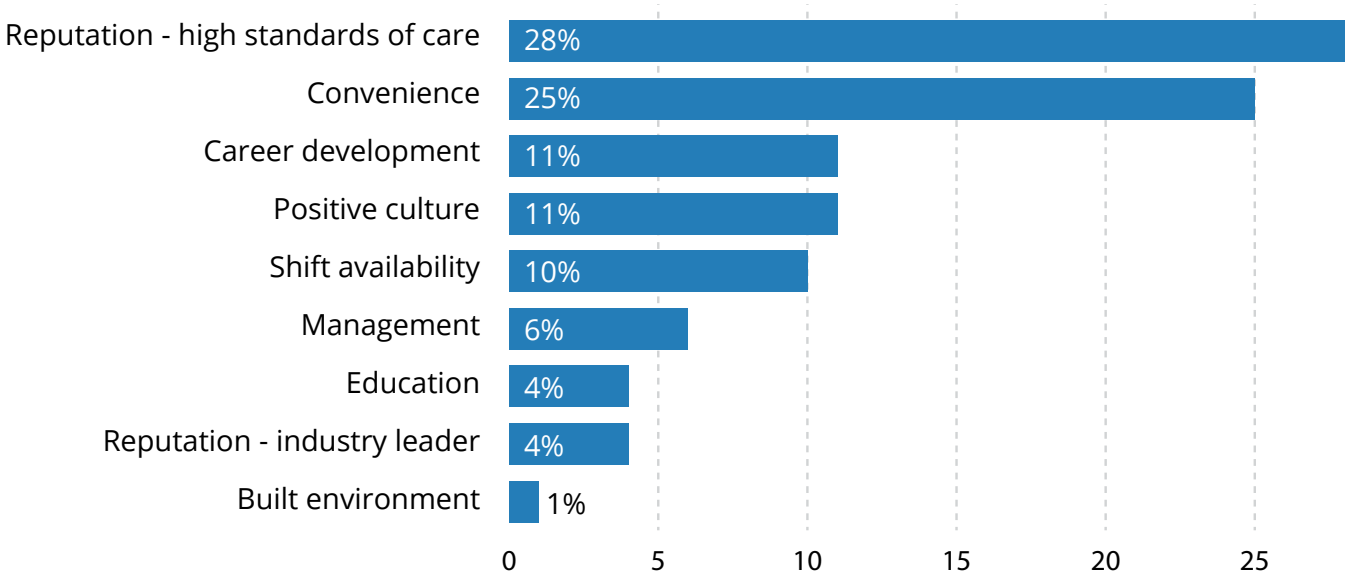
- There was a decrease in employee numbers between the ages of 20-24 and between the ages of 40-44
- Other age brackets reflected a non-statistical change in employee numbers during this timeframe
- Highest staff turnover occurred in the workforce aged between 20-24 years

Planned Tenure of Employees

- The majority of employees that had worked at an organisation for 3-10 years indicated their intention to remain with the organisation
- There is a significant number (40%) of current employees who are unsure how long they plan to remain working in residential aged care

Employee Attractors

The key factors driving talent acquisition are listed here. They are ranked from the highest to the lowest scoring factor.



EMPLOYEE SATISFACTION SURVEY

Purpose Of This Survey

The purpose of the Employee Satisfaction Survey is to measure staff engagement with their organisation and their workplace.

In this context, engagement is the extent to which employees commit to something or someone in the organisation, factoring in how long they stay with that organisation as a result of that commitment.

This annual survey provides an opportunity for all employees to provide honest commentary and make suggestions for improvement on various aspects of their work life.

The workplace domains are:

1. Teamwork
2. Performance and Feedback
3. Consumer Centred Care and Services
4. Decision Making
5. My Work Area
6. External Relationships
7. Information and Communication
8. Skills, Knowledge and Training
9. Work Health and Safety
10. Equipment
11. Leadership in my Organisation

Two Organisational Promotor Questions are then asked:

1. How likely is it you would recommend this organisation to family and friends as a great place to work?
2. How likely would you be to recommend the care and services provided at this home to family and friends?

Also, an opportunity to comment on general workplace satisfaction and dissatisfaction is provided.

Respondents were also asked if they had any other comments or suggestions for improvement.

Teamwork

The verbatim comments have three (3) main foci:

1. **Improvement in team culture by:**
    - Building greater respect for each other within teams
    - Actively reducing the levels of bullying and harassment between employees and reducing gossip about other employees
    - Showing greater support for each other in the workplace by assisting each other as needed outside of employee roster allocation areas
2. **Communication**
    - Improve the level and methods of communication from management
    - Improve the quality of the information shared at shift handover
    - Improve general incidental communication

3. Education

- Improve education in the area of team building
- Improve mentoring for all employees
- Strengthen and standardise new starter orientation programs
- Improve knowledge and understanding of organisational policies and processes
- Provide opportunities for staff to upgrade existing qualifications through the Vocational Education Training (VET) sector

Performance and Feedback

The verbatim comments present overall negativity concerning performance and feedback processes.

Factors that impact on employee performance were identified as being rostering, workplace culture and management.

1. Rostering

- Inadequate staffing levels
- Poor rostering practices (for example, lack of continuity in rostering RNs in a care area)
- Excessive documentation

2. Workplace Culture

- Negative workplace culture of gossiping, bullying and harassment
- Poor communication within home

3. Management

- Inadequate and poorly maintained equipment
- Inadequate IT resources for documentation purposes
- Low visibility of management, especially on weekends
- Inexperienced managers
- Lack of staff recognition programs, especially to recognise unpaid hours of work and lack of meal breaks

Consumer Centred Care and Services

There were five (5) main foci from the verbatim comments in this domain:

1. Staffing

- Staffing was inadequate across all shifts, as well as care and service areas
- Higher remuneration and better working conditions are required
- A redesign of workflow to increase the amount of time spent with each resident was needed for Consumer Directed Care to be implemented
- Improved organisational fit for new employees to support workplace culture through improved recruitment practices
- Improved access to Employee Assistance Programs (EAP) is needed

2. Education

- There is a lack of respect and appreciation towards education, specifically in relation to Consumer Directed Care (CDC). This is central to achieving Aged Care Quality Standard 1
- Education is required to improve organisational culture and to improve teamwork

3. Documentation

- Reduce the level of required documentation to enable more time with residents

4. Complaint handling process

- Improve the way complaints are managed

5. The Built Environment

- Upgrade existing stock and equipment
- Improve the maintenance of stock and equipment

Decision Making

Respondents identified four (4) main foci for improvement that impacted decision making:

1. Staffing

- Improve the quality of managers
- Improve the quality of registered nurses (RNs) and team leaders
- Performance manage poor employee performance
- Performance manage poor employee attitude
- Review all Position Descriptions in line with Aged Care Quality Standards*

2. Education

- Improve RN capability
- Improve skills and knowledge in care and services planning for all employees
- Provide specialist pain management education
- Provide specialist palliative care education

3. Clinical Governance

- Review clinical procedures and processes in line with Aged Care Quality Standards* and Consumer Directed Care
- Review policies and processes related to antimicrobial stewardship
- Improve the frequency of medical officer visits to residents

4. Organisational Governance

- Review feedback management systems in relation to complaint handling
- Review and update all policies and processes related to organisational governance (Aged Care Quality Standard 8)

**Australian Government 2019*

My Work Area

Respondents identified three (3) main foci in this domain.

1. **Staffing**
    - Increase staffing levels
    - Eliminate the culture of fear in the workplace
    - Recognise and improve competency levels
    - Performance manage underperforming staff
    - Utilise appropriate skill mix to match staffing skills to acuity
    - Increase staffing levels
2. **Workplace Culture**
    - Address sick leave due to excessive work loads
    - Replace absent staff
    - Rectify the distrust in management due to inability to address staff-to-staff complaints, obvious favouritism, and inconsistent performance management outcomes
    - Address bullying, harassment and gossiping
    - Improve staff recognition
    - Staff feel undervalued
    - An unawareness from management concerning poor culture
3. **Clinical Governance**
    - Improve antimicrobial stewardship
    - Improve Work Health and Safety
    - Improve skill and knowledge of RNs
    - Address inappropriate use of restraints to manage workflow
    - Improve overall competency levels of all employees

External Relationships

The response levels to this question were low. Responses demonstrated limited understanding of the role, value and importance of external relationships in care and services provision.

The responses in this domain were polarised with some respondents stating there were excellent relationships with the Local Health District and the local community, while others stated there was a clear need to improve. Areas include:

- Relationships with local medical officers
- Relationships with suppliers, in particular laundry outsourcing
- Specialist education to deal with elder abuse
- Time allocated to develop external relationships

Information and Communication

Positive verbatim comments focused on:

- The respect that team leaders and registered nurses have for the views of direct care staff
- Good relationships with the organisation's management
- Good relationships with the Board of Directors

Respondents identified two (2) main foci for improvement in this domain - management and rostering.

1. Management

- Address reluctance to change practices
- Roster a supervisor on each shift
- Be honest in communication with employees
- Increase frequency of staff meetings
- Address culture of bullying, harassment and gossiping
- Promote teamwork
- Improve In-service education

2. Rostering

- Increase time provided for handover by extending shift overlap time
- Stabilise RN allocations to enable follow up appointments to be made

Skills, Knowledge and Training

In this domain employees identified two (2) areas of concern for improvement - education and staffing.

1. Education

- A need for more Education Needs Analyses with education planned accordingly
- The need for a blended approach to learning in the workplace, moving away from an on-line education focus
- The need for opportunities, based on merit, for employees to upgrade VET qualifications, in particular from Certificate III to Certificate IV Care qualifications
- A need to assess employee learning entry behaviours on recruitment to enable a tailored and therefore more effective approach to learning
- A lack of education opportunities on weekends and for night duty staff
- A lack of flexibility in mandatory education delivery for weekend staff and night duty staff
- A need for CDC focused education based on local care environments
- A need for education for changes in roles aligned to CDC and other regulatory changes

2. Staffing

- Lacked appropriate skill mix for high acuity residents
- Lacked specialised skills in complex care areas such as pain management and palliation
- Rosters were inadequate for safe care delivery and relied on unpaid overtime and brand loyalty to meet resident needs
- Buddy shifts were insufficient to cover the multi-tasking required on a shift-by-shift basis, in particular for registered nurses and team leaders
- Poor staff recognition for good employees
- High levels of bullying, harassment and gossiping that undermines team work
- More staff meetings were needed to improve general communication within the home
- Staff meetings to be held on weekends and at times that meet the needs of night duty staff

Work Health and Safety

In some homes, employees identified that good meeting structures were already in place, resulting in a quick resolution of Work Health and Safety issues.

Overall, however, there was an expressed view that improvements were needed in three (3) areas. These are - the role of management, communication and education.

1. The role of management

- Managers to be more accessible on a 24/7 basis to support the resolution of issues as they arise
- Enforcement of Safe Work Practices across all workplace employee designations to reduce incidents
- Managers to be active advocates for staff amenities, such as heating and cooling
- Increase reactive maintenance hours to ensure a safe workplace for employees and residents

2. Communication

- An overall improvement is required to disseminate information about Work Health and Safety
- Introduce an e-maintenance system to streamline cumbersome paper-based requests for maintenance and enhance the response turnaround time

3. Education is needed in:

- Safe Work Practices
- Correct use of Personal Protective Equipment (PPE)
- Correct use of equipment in general

Equipment

The verbatim responses in this domain revealed a staff culture that engaged in hiding equipment that was in good working order and other supplies so that they could have access to these items on their shift. Examples provided included:

- Lifters, bathchairs and wheelchairs (stored in empty rooms)
- Gloves
- Items of linen, such as face washers and towels

These comments are indicative of a perception of inadequate and malfunctional equipment and supplies for basic care and services delivery.

Verbatim responses clearly fell into two (2) categories - Work Health and Safety and Information Technology.

1. Work Health and Safety

- Broken, unsafe equipment in need of repair or replacement. Examples provided were comfort chairs, lights, tables, skip bins and shower chairs
- Slow turnaround times on repair or replacement of basic equipment
- Equipment that required cleaning and for this cleaning to be on a more regular basis

- Workplace stress as a consequence of poor-quality equipment
- Inadequate PPE, such as gloves
- Inadequate supplies of plastic bags
- Inadequate supplies of linen items, such as face washers

2. Information Technology (IT)

- Inadequate laptops for documentation purposes
- Faulty IT equipment
- Poor internet service to the home
- Poor internal communications methods related to IT systems

Leadership

While there was positive verbatim commentary in relation to leadership, a clear trend from The Employee Satisfaction Survey revealed an overall lack of confidence in leadership on the whole.

Positive commentary highlighted:

- Approachable and proactive managers
- Engaged staff
- Cultural sensitivity
- Supportive towards activities
- Respect for the management team
- Support for employees
- A good Employee Assistance Program (EAP) program
- Active listening to suggestions for improvement

Verbatim negative commentary highlighted:

- A disengaged workforce due to leadership
- An inexperienced workforce with poor English literacy levels due to poor recruitment processes

- A pervading and destructive culture of bullying, harassment and gossiping that went unchecked by managers
- Homes that function in spite of the management, due to resilient and resident focused employees
- Non-consultative management teams
- Poor performance management processes, in particular for underachieving, non-compliant employees
- Managers that do not manage employees who repeatedly take sick leave
- Managers do not replace employees who ring in sick, placing stress on other employees to get the work completed
- Some managers are poor communicators
- Employees fear retribution if they raise issues at meetings
- Managers do not promote the organisations values
- Managers showing favouritism to some employees

In the area of education, employees identified:

- A need for education to build teamwork

Recommendation

Employees were asked the reasons they would recommend the organisation as a great place to work.

Employee responses fell into five (5) categories:
Culture, Workforce, Management, Work Health and Safety, and Organisation profile.

1. Culture

Positive recommendations in relation to culture were as follows:

- Friendly and supportive workplace
- Fairness in their workplace
- A team work environment
- Job security and satisfaction

2. Workforce

There was a cross-section of responses, covering both positive and negative responses in relation to the workforce.

Positive:

- Provides good care
- Supports independence
- Caring and genuine
- Friendly
- Committed
- Gentle

Negative:

- Poor remuneration and conditions
- Poor remuneration systems leading to frequent mistakes with remuneration
- Understaffing for acuity levels
- Inadequate new starter orientation
- Poor staff selection processes
- Low staff morale

3. Management

Polarised commentary was provided concerning management.

Positive:

- Good managers
- Flexible shifts provided
- Available
- Supportive

Negative:

- Rules not uniformly applied
- Inexperienced managers
- A 'them and us' perception
- Staff under appreciation
- Poor communication

4. Work Health and Safety

Safety, equipment and cleanliness proved to be the three (3) key recommendation indicators.

Positive:

- Good physical environment

Negative:

- More new equipment needed
- Improve environmental safety
- Provide a clean environment

5. Organisational profile

Positive recommendations in relation to an organisation included:

- Good reputation
- Provides good care
- Policy and Process driven
- Professional
- Provides good food

Recommendation

Employees were asked if they would recommend the care and services provided in their home to family and friends.

Employee responses fell into four (4) categories: Management, Culture, Care, and Work Health and Safety.

1. Management

Positive and negative recommendations were driven by the following:

Positive:

- Good managers
- Approachable
- Supportive
- Professional

Negative:

- Poor communicators
- Slow to resolve issues
- Inadequate leadership skills
- Poor staff recognition
- Tolerates poor care practices
- Tolerates underperforming staff
- Understaffing (for example, not replacing sick leave)

2. Culture

While there were encouraging comments highlighting positive work environments and culture, concerns again were raised in relation to bullying.

Positive:

- Caring and friendly co-workers
- Supportive colleagues

Negative:

- General improvement needed
- No compassion
- Poor with high levels of bullying, harassment and gossiping
- Lack of respect for residents

3. Care

Organisations that successfully delivered quality care to residents are viewed as far more favourable. Failure to meet these standards together with staff workload are noted as key negatives.

Positive:

- Good quality care provided
- Understand duty of care
- Good services
- Good reputation for care
- Fresh cooked food
- Professional and skilled staff
- Good community interface
- Good team spirit
- Good education for CDC

Negative:

- Workloads too high to give good care
- Poor care levels and outcomes
- Poor food
- Improve activities

4. Work Health and Safety

Unsurprisingly, cleanliness, maintenance and workloads are key Work Health and Safety factors.

Positive:

- Safe environment
- Clean environment
- Well maintained environment
- Resort-like welcoming environment
- Good gardens

Negative:

- High workloads dangerous
- Home is too small

Recommendation

Employees were then asked for open-ended comments on what most satisfies them about their work.

Employee responses fell into three (3) categories: Culture, Workforce and Work Health and Safety.

1. Culture

Staff togetherness, progression and recognition formed the foundation for most responses. These included:

- Teamwork
- Staff mentoring
- Friendly and caring staff
- Opportunities for education
- Providing safe care
- Happy workplace
- Good culture
- Feel valued
- Supportive environment
- Core values
- Generous organisation
- Management provide good feedback
- Good management
- Resident focus: good food, promotes self-worth and appreciation from residents

2. Workforce

Responses indicated a desire for:

- Security of tenure and hours
- Roster flexibility
- Variety in work
- Role autonomy

3. Work Health and Safety

Job satisfaction in this area pointed towards the following:

- Good built environment
- Good equipment

Recommendation

Employees were then asked for open-ended comments on what most dissatisfies them about their work.

Employee responses fell into five (5) categories:
Workforce, Management, Culture, Work Health and Safety and External Influences/Pressures.

1. Workforce

Feedback centred around culture and capability:

- More staff required for quality care and service provision
- Too many poor performers
- More RNs needed
- Poor teamwork
- Poor remuneration
- High volume sick leave
- Poor skills mix
- Staff allocations
- Workload too high in documentation
- More IT education needed

2. Management

Responses centred around culture, recognition and capability:

- Poorly skilled
- Poor communicators
- Will not address underperformance/poor performance
- Not supportive
- Favouritism in rostering
- Poor complaint handling
- Maintain staff as casual for too long

3. Culture

Again, answers matched trends from previous questions:

- Bullying, harassment and gossiping
- Discrimination
- Roster favourites

4. Work Health and Safety

Employee dissatisfaction focused on the following factors:

- Poor quality equipment
- Broken equipment
- Insufficient equipment
- Kitchen processes

5. External Influences/ Pressures

Comments pointed towards the pressures surrounding aged care's fast changing environment, as a result of the Royal Commission into Aged Care Quality and Safety 2019*, including:

- Compliance requirements
- Too many regulatory changes
- Negative media

Royal Commission into Aged Care Quality and Safety 2019

Recommendation

The final question on the Employee Satisfaction Survey asks for any other comments for improvement.

Comments and suggestions fell into three (3) categories: Workforce, Management, and Care.

1. Management

- Improve communication
- Improve the culture
- Improve consultative focus
- Listen to staff
- Be more involved at the care delivery level
- Improve skills
- Further develop homes to sub-acute level
- Improve performance management processes
- Recruit appropriate staff
- Improve feedback to staff
- Manage sick leave
- Improve staff rotation
- Improve access to Employee Assistance Program (EAP)
- Improve quality and quantity of equipment
- Move casual staff to permanent status
- Stop favouritism in rostering
- Address bullying, harassment and gossiping in the workplace

2. Workforce

- Increase numbers of RNs
- Increase overall staff numbers to address staff shortages
- Increase administrative staff support levels
- Improve external and internal education
- Improve staff amenities, for example, TV in staff room, free staff meals, free staff WiFi
- Fairer access to staff education opportunities
- Improve remuneration
- Keep good teams together
- Improve teamwork

3. Care

- Place more value on the resident
- Improve the quality and choice within the activity program
- Improve the quality of handovers
- Improve the quality of equipment

"Organisations that successfully deliver high quality standards of care to residents is a key driver of employee satisfaction."

– Employee verbatim comment

Summary

The Workforce Experience highlights a resilient workforce that functions despite the external and internal stressors it has been placed under.

Repeated themes centre around:

- **A pervading culture of bullying and harassment**
- **Management that is reluctant to address hard issues**
- **Inconsistencies in rostering practices**
- **A resistance to change in care and service provision modelling**
- **A mismatch between knowledge, skills and resident acuity**
- **Varying IT capacity and access**
- **Staff turnover and poor recruitment practices**
- **A lack of recognition for good work**
- **Disconnected and invisible managers**
- **Poor complaint and feedback management**
- **Poor compliance with protocol-based issues**

Section Four

The Care Experience

All Government funded Aged Care homes are mandated to deliver safe and quality care and services to consumers. A consumer directed model of care and service delivery is central to this mandate. The QPS Benchmarking Clinical Experience audits focus on lead clinical indicators to mitigate consumer risk.

THE CARE EXPERIENCE

Data was collected using the QPS Benchmarking Clinical Indicators, Quality of Care and Clinical Care audits. These audit tools are aligned to;

- The Aged Care Quality Standards and requirements*
- The National Quality Indicator Program*

Reference is also made to the impact of the Aged Care Funding Instrument* on resource allocation and care hours.

QPS Framework Alignment to the Aged Care Quality Standards*

All QPS Benchmarking Clinical Indicators and Audits are mapped to the Aged Care Quality Standards*. The Aged Care Quality Standards* are clearly identified on each QPS Benchmarking Audit Tool. The QPS Benchmarking Audits are regularly reviewed for compliance with The Aged Care Quality Standards*.

Alignment of the QPS Framework to the National Quality Indicator Program (NQIP)*

The National Quality Indicator Program* commenced on 1 July 2019. This reporting is mandatory for all approved providers of government subsidised residential aged care (Australian Government 2019).

Every residential aged care home that receives Commonwealth Government Funding must participate in this Quality Indicator Program*.

Every residential aged care home must currently report against three (3) Quality Indicators:

- Pressure Injuries
- Use of physical restraint
- Unplanned weight loss

Monthly data is gathered through the QPS Benchmarking Audit Framework for these Quality Indicators.

The results of this data collection are published on the GEN Aged Care Data website*.

At the time of writing this report three (3) quarters of data had been collected and submitted through QPS.

The QPS Benchmarking Clinical Indicators and Quality of Care Audit Domains

The QPS Benchmarking Clinical Indicators and Quality of Care Audit data set presented in this report reflect deidentified aggregated data between 2017 and 2019.

These audits review the following clinical domains in line with external and internal compliance standards.

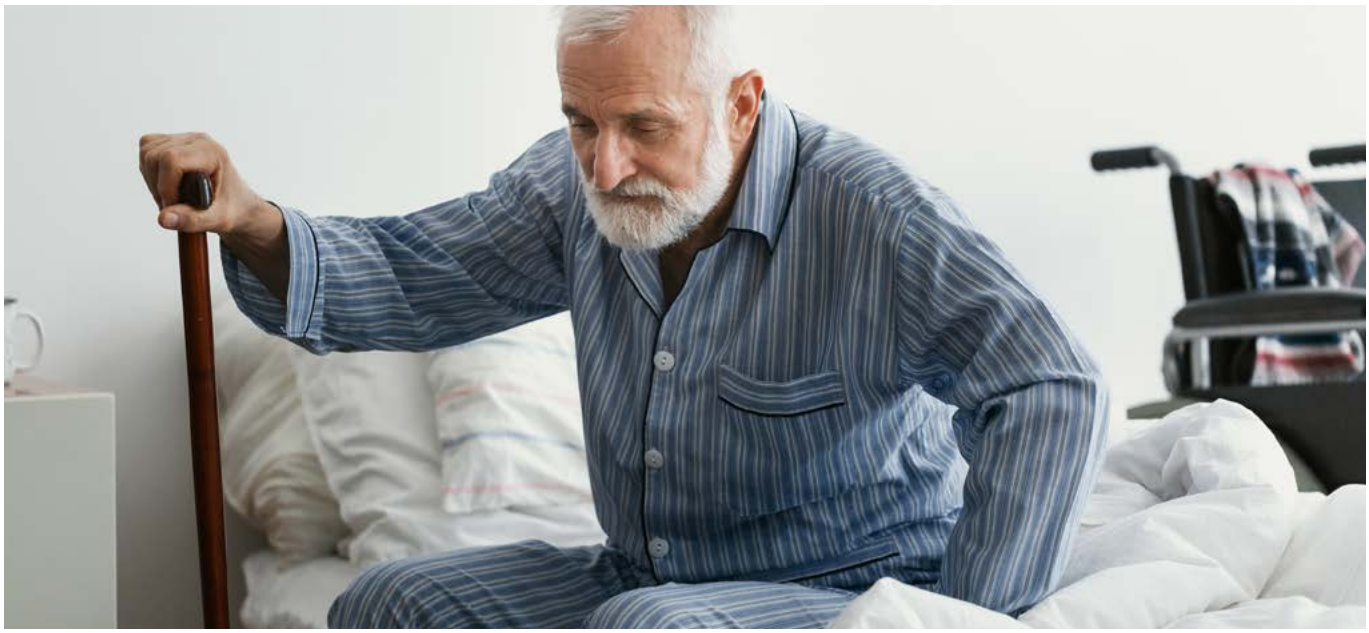
*Australian Government 2019
Australian Government Department of Health 2019
Australian Government Aged Care Quality and Safety Commission 2019
Australian Government Services 2019
www.gen-agedcaredata.gov.au

QPS Benchmarking Clinical Indicators and Quality Care Audit Domains

QPS BENCHMARKING CLINICAL CARE INDICATOR	QPS BENCHMARKING QUALITY OF CARE AUDIT
Unplanned Weight Loss	**Resident Weights**
Restraint (Physical-General, Chemical-General, Physical-Dementia Specific, Chemical-Dementia Specific)	**Blood Glucose Levels**
Falls (Total-General, With Injury-General, Without Injury-General, Total-Dementia Specific, With Injury-Dementia Specific, Without Injury-Dementia Specific)	**Routine Observations**
Infections (Antimicrobial Stewardship)	**Bowel Charts**
Aggressive Episodes (General, Dementia Specific)	**Sensory Loss**
Unplanned Transfers	**Specialised Needs**
Pressure Injuries (Total, Facility Acquired, Externally Acquired)	**Palliative Care**

This report also gathers data related to the Aged Care Funding Instrument* and Care Staff Hours. The results of the QPS Benchmarking medication management suite of audits is also included in this report.

Australian Government Services 2019



The Aged Care Funding Instrument (ACFI*)

The ACFI* is a resource allocation instrument used to assess and measure the level of care of residents living in residential aged care homes. The ACFI* is the basis for funding allocation for residential aged care homes.

The ACFI* assessment has three (3) domains: Activities of Daily Living, Behaviours, and Complex Health Care.

Data regarding the ACFI* was collected by QPS Benchmarking between 2017 and 2019 in the following domains:

- ACFI* funding per resident per day
- ACFI* Activities of daily living (ADL)
- ACFI* Behavioural care needs (BEH)
- ACFI* Complex health care (CHC).

Changes in care staff hours data has also been collected.

ACFI Funding

For the purposes of QPS data collection, ACFI* funding is defined as the gross dollars received per resident per day from the ACFI* funding system for all ACFI* assessed residents.

There has been a modest increase of $9.60 per resident per day between 2017 and 2019.

This does not cover the costs associated with the increase in Care Staff hours for the same time period.

As demonstrated by the QPS clinical outcome data, the modest ACFI* funding increases have not kept pace with the significant increase in resident frailty and acuity and subsequent rise in care needs. The rise in care needs results in a demand for more staff time and the utilisation of specialist knowledge and skill levels. Time taken to complete ACFI* assessments, reassessments and submissions is real time lost in care delivery.

ACFI* Activities of Daily Living (ADL), Behavioural and Complex Needs Scores

There has been no significant increase in the QPS Industry Benchmark for ACFI*-Complex Needs Score or the ACFI*-Behavioural Score between 2017 and 2019. The ACFI* ADL score has increased by three (3) points.

Care Staff Hours

There has been an increase in Care Staff Hours of 14 mins per resident per day between 2017 and 2019.

**Australian Government Services 2019*

QPS Benchmarking Clinical Indicators

QPS Benchmarking has a comprehensive suite of Clinical Indicators and Audits.

These Clinical Indicators include:

- **Unplanned Weight Loss**
- **Restraint (Restrictive Practices)**
- **Falls**
- **Infections (Antimicrobial Stewardship)**
- **Unplanned Transfers**
- **Aggressive Episodes**
- **Pressure Injuries**

**Australian Government Services 2019*

Unplanned Weight Loss

For the purposes of QPS data collection, unplanned weight loss is defined as those residents with no written or planned strategy to lose weight; and includes the total number of residents with a weight loss of 3kgs or more over a three (3) month period; or consecutive weight loss of any amount every month for a three (3) month period, expressed as a percentage of the number of residents whose weight was monitored. This reflects the reporting requirements for the mandatory National Quality Indicator Program*.

Australian research has identified that the prevalence of malnutrition in residential aged care homes approximates 50% (Price Waterhouse Cooper 2019 p. 15). Anchor Excellence have identified unexpected and unplanned weight loss as a high impact clinical risk (Anchor Excellence 2019).

There has been a 9% increase in unplanned weight loss between 2017 and 2019.

This is due to:

- Increased use of validated assessment tools by clinicians, in particular for ACFI* and NQIP* purposes
- Increased recognition that unexpected and unplanned weight loss is a lead clinical indicator for high clinical risk
- Increased surveillance by the Aged Care Quality & Safety Commission in relation to serious risk contributing factors
- Increased acuity of residents on admission
- Increased age of residents on admission

Restraint (Restrictive Practice)

The Royal Commission's Interim Report into Aged Care Quality and Safety (2019 p. 194) defines a restrictive practice as 'activities or interventions, either physical or pharmacological, that have the effect of restricting a persons' free movement or ability to make decisions'.

QPS Benchmarking restrictive practice data collection reflects this definition.

Restraint Physical-General

Physical Restraint Criteria

The QPS Benchmarking Criteria for reporting physical restraint is based on the Commonwealth Department of Health criteria (2019).

The QPS Benchmarking Restraint Physical-General aligns with the mandatory National Quality Indicator Program* and QPS Benchmarking submits this data quarterly directly to the Commonwealth Department of Health.

Examples of physical restraint devices used to restrict a consumer's voluntary movement or behaviour can include bed rails, concave mattresses, water chairs, positioning the bed against a wall and lap belts.

For QPS Benchmarking data collection, physical restraint is defined as the total number of residents physically restrained, expressed as a percentage of the average daily occupancy of residents.

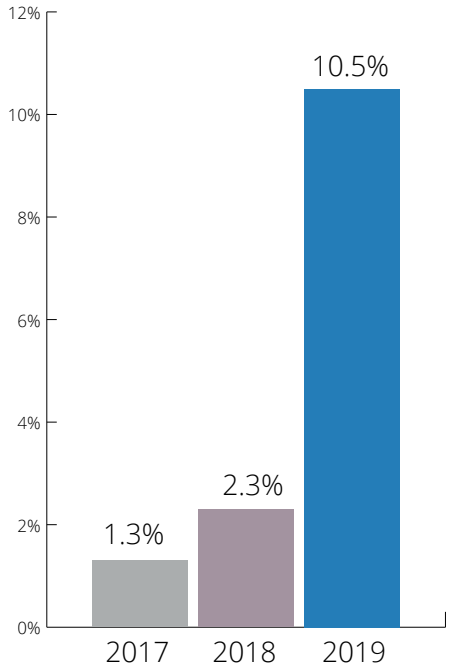
There is an increase of 2% in the use of Restraint-Physical General between 2017 and 2019.

*Australian Government 2019
Australian Government Services 2019
Australian Government Department of Health 2019

QPS Chemical Restraint Criteria

Restraint Chemical-General

The QPS Benchmarking Criteria for reporting chemical restraint is based on the Commonwealth Department of Health criteria.



This Graph represents the increases in Restraint Chemical – General between 2017 and 2019. In particular there is a significant increase between July and September 2019.

'Chemical restraint means a restraint that is, or that involves, the use of medication or a chemical substance for the purpose of influencing a person's behaviour, other than medication prescribed for the treatment of a diagnosed mental disorder, a physical illness or a physical condition.'

For the purposes of QPS Benchmarking data collection, chemical restraint is defined as the total number of residents chemically restrained, expressed as a percentage of the average daily occupancy of residents.

Data from Dementia Specific/Memory Support Units is excluded from the Restraint Chemical General data set.

**Australian Government 2019*

Notes: In 2018 the definition of chemical restrictive practices was changed to be far broader, including the chemical restrictive practices which were used as part of any diagnosis. This has resulted in a significant increase in 2019.

Causal factors may include:

- **Later admission to residential aged care**
- **Fewer dementia memory support beds available**
- **Nominated Representative not wanting a dementia specific unit, for example, due to stigma and media factors**
- **Previous life experience influencing choice of accommodation (for example, Post Traumatic Stress Disorder (PTSD) or persecution)**

Restraint Physical-Dementia Specific

For QPS Benchmarking data collection, Physical Restraint-Dementia Specific is defined as the total number of residents physically restrained in an enclosed area, expressed as a percentage of the average daily occupancy of residents.

There has been a 2% increase in the use of physical restraint in dementia specific areas between 2017 and 2019.

Restraint Chemical-Dementia Specific

For the purposes of QPS Benchmarking data collection, Restraint Chemical-Dementia Specific is defined as the total number of residents chemically restrained in an enclosed area, expressed as a percentage of the average daily occupancy of residents.

There has been a significant 19% increase in the use of Restraint Chemical-Dementia Specific between 2017 and 2019.

This significant rise can be attributed to:

- **Improved surveillance in the use of pharmacological restrictive practices**
- **Changes in definition of chemical restrictive practice that unlinked the measure to diagnosis in 2018 (as referenced earlier)**

Falls

The highest number of deaths in residential aged care are as a result of the consequences of falls (Anchor Excellence 2019).

Of the consumers who fall each year, 20-32% of falls will result in a fracture (PricewaterhouseCoopers 2019 p.18). The older the consumer, the higher the risk of falling.

Of all fall related deaths, 85% were aged over 70 years of age*

The residential care sector performance data July-September 2019* identified falls prevention and management as the third most frequent complaint received by the Aged Care Quality and Safety Commission*, accounting for 13% of the complaints they received.

It is significant that falls with fractures is to be included in the National Quality Indicator program (Australian Government 2019).

The QPS Benchmarking criteria for reporting total falls is evidence based on the World Health (WHO) (2018) and supporting documentation from the National Institute for Health and Care Excellence (2018).

WHO (2018) define a fall as an event which results in a person coming to rest inadvertently on the ground or floor or lower level as a result of the following:

- An environmental factor
- Medical condition
- Unknown cause

The fall may or may not result in injury and may be witnessed or unwitnessed.

Falls - General

For QPS data collection purposes, Total Falls are defined as all incidents where the resident slips, trips or falls, expressed as a percentage of the average daily occupancy of residents.

Falls are also audited as Falls Without Injury-General and Falls with Injury-General.

Data from Dementia Specific/Memory Support Units is excluded from the Falls-General data set.

Between 2017 and 2019 there was a 12% increase in the number of Falls-General.

**Australian Government 2019*
Aged Care Quality and Safety Commission 2019
PricewaterhouseCoopers 2019 p. 18

Falls General - With Injury

Resident Falls with Injury are defined as each event that is reported, where the resident slips, trips or falls during their stay and sustains an injury that results in the consumer requiring treatment. These injuries requiring treatment can be major (for example, a fracture) or minor (for example a bruise).

There was a minimal 1% increase in the number of Falls with Injury recorded.

Falls General - Without Injury

A resident fall without injury is any fall that requires no treatment at home level by a medical officer or in an acute setting.

Within the data sub-sets (Falls-without injury) there was a steady increase of 11% in the numbers of falls recorded. There was a seasonal increase in the July-September quarter each year.

Falls - Dementia Specific

Falls Dementia Specific is defined as all incidents where the resident slips, trips or falls, in an enclosed area, expressed as a percentage of the average daily occupancy of residents.

Falls Dementia Specific are also audited as Falls Without Injury-General and Falls With Injury-General.

There has been an increase of 21% in the number of Falls-Dementia Specific between 2017 and 2019, with a seasonal spike between July and September each year.

Falls - Dementia Specific With Injury

There has been a steady increase of 3% in the number of Falls-Dementia Specific with Injury between 2017 and 2019.

Falls - Dementia Specific With No Injury

There has been a steady increase of 18% in the number of in Falls-Dementia Specific with no injury between 2017 and 2019.

Contributing factors are:

- **Improved rigour in reporting mechanisms**
- **Increased surveillance by the Aged Care Quality and Safety Commission***
- **Residents and their families exercising Dignity of Choice in relation to freedom of movement**

Infections (Antimicrobial Stewardship)

Total Infections

The QPS Benchmarking criteria for reporting infections is evidence based on the McGreer Infection Surveillance Criteria (2012) and the Australian Commission on Safety and Quality in Health Care (2019).

Total Infections includes all types of resident infections, with and without pathology, expressed as a percentage of the average daily occupancy of residents.

Infection rates have increased by 7% between 2017 and 2019.

QPS data collected reflects the spike in respiratory infections from the July-September period each year as a direct result of the influenza season.

At the time of writing this report, The Commonwealth Department of Health has mandated influenza immunisations for all employees, contractors, volunteers, and visitors to residential aged care homes. Residents are encouraged to immunise, however, this is not mandated.

Unplanned Resident Transfers

There has been a 4% increase in the number of unplanned transfers to hospital between 2017 and 2019.

In particular, the seasonal increase is noted between July and September each year. This can be attributed to an increase in infections, specifically influenza type illnesses. This was despite active campaigns within homes to improve vaccination rates for staff, residents and visitors to the home.

The other increases are thought to be due to:

- The life risk of a resident on admission
- Dignity of risk for residents
- Increased falls monitoring
- Choice made to transfer by medical officer, resident or family
- A more risk adverse care environment
- Organisational clinical governance guidelines regarding transfer criteria

Aggressive Episodes - General

The QPS Benchmarking criteria for reporting aggressive episodes is based on the Commonwealth Department of Health criteria (2004) and the Dementia Australia definition (2019).

An aggressive episode is defined as an incident where any resident uses threatening and/or assaultive behaviour, where a staff member or other person finds this behaviour threatening or assaultive. The verbal or physical assault may or may not result in injury.

Verbal assault includes:

- Verbal threats that express an intent of verbal or physical harm
- Offensive and/or abusive verbal language (swearing, curses, obscenities, profanities)
- Accusations with verbal threats/blame
- Verbal threats that are assaulting in nature

Physical assaults include:

- Physical damage to objects (striking/hitting out)
- Bodily assault to other persons resulting or not resulting in injury (striking/hitting out)
- Bodily assault to themselves resulting or not resulting in injury (tearing or scratching)
- Physical disruption/intrusion

Aggressive episodes are defined as the total number of resident verbal or physical aggressive episodes, expressed as a percentage of the average daily occupancy of residents.

Data from Dementia Specific/Memory Support Units is excluded from the Aggressive Episodes-General data set.

Aggressive Episodes - General

There is an increase of 2% in reported Aggressive Episodes-General between 2017 and 2019.

Aggressive Episodes - Dementia Specific

Aggressive Episodes-Dementia Specific are defined as the total number of resident verbal or physical aggressive episodes in an enclosed area, expressed as a percentage of the average daily occupancy of residents.

There is a rise of 15% in Aggressive Episodes-Dementia Specific between 2017 and 2019. This can be attributed to:

- Admissions later in the progress of dementia
- Increased awareness of Dignity of Risk
- Targeted reduction in the use of psychotropic medications
- More informed Nominated Representatives
- Skill and knowledge gaps in employees
- Lack of specialised employees in this discipline
- Protracted wait times for externally sourced services such as Dementia Behaviour Management Advisory Service (DBMAS) and psychogeriatrician consultations
- Hypervigilance due to the impact of the Royal Commission (2019) findings in this domain
- Early intervention due to negative media

Pressure Injuries - Total

For the purposes of QPS Benchmarking data collection, Pressure Injuries - Total include those acquired by the resident during the time care has been provided within the home and those acquired by the resident prior to admission, on transfer to hospital or during periods of leave.

Pressure Injuries are also audited as Pressure Injuries-Facility Acquired and Pressure Injuries-Externally Acquired.

Facility Acquired pressure injuries are those acquired by the resident during the time care has been provided within the home, expressed as a percentage of the average daily occupancy of residents.

Externally Acquired pressure injuries are those acquired by the resident during the time care has not been provided within the home, and includes prior to admission, on transfer to hospital or during periods of leave, and expressed as a percentage of the average daily occupancy of residents.

The QPS Benchmarking criteria for reporting pressure injuries is evidence-based, utilising the Pan Pacific Pressure Injury Alliance Clinical Practice Guidelines (PPIA) (2019).

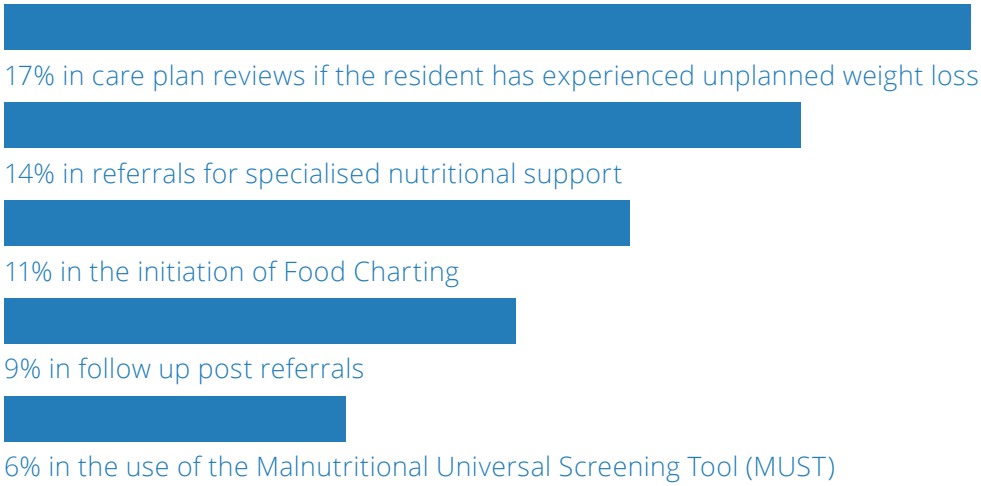
There has been a steady 2% rise in the level of Facility Acquired Pressure Injuries between 2017 and 2019. This can be attributed to:

- The gaps in employee knowledge, skills and experience
- Lack of specialised skills in the area of high impact clinical risk
- The increased age and acuity of consumer's entering residential aged care
- Lack of understanding of value in the clinical handover process
- The impact of reporting requirements for the NQIP*
- The rate of externally acquired pressure injuries has shown a steady 1% increase due to the unplanned transfers to the acute hospital sector.

**Australian Government Department of Health 2019*

QPS BENCHMARKING QUALITY OF CARE AUDIT

The clinical indicators for residents' weights demonstrate significant improvement between 2017 and 2019. In particular there is an increase of:



Residents Weights

Changes in a resident weight that is unplanned or unexplained is an important clinical indicator that can be related to systemic changes.

For this clinical index, residents' weights are measured monthly.

The improvements demonstrated in the above graph are related to the introduction of unplanned weight loss within the National Quality Indicator Program*. The introduction of the International Dysphagia Diet Standardisation Initiative (2017)(IDDSI), a multi-level diet program for weight maintenance is also a significant contributor to improved weight surveillance.

There was a decrease of 2% in the care plan identifying interventions implemented in response to weight loss.

Blood Glucose Monitoring

The data for Blood Glucose Monitoring revealed an increase in compliance with the clinical process related to blood glucose measurements and documentation between 2017 and 2019.

Compliance improvements were identified in:

- BGL measurement according to medical officer orders (2%)
- Actioning any measurements outside of an accepted range for a resident (3%)
- Care plan management (1.3%) including monitoring and documenting BGL according to care plan (2.5%)

There was a decline of 5% in clinical governance procedures in relation to clinical education and competency assessment rates for registered nurses in insulin administration.

This is an important finding as compliance with blood glucose monitoring plays a critical role in resident

**Australian Government Department of Health 2019*

wellbeing. Blood glucose measures are a lead clinical indicator guiding clinical management processes, specifically in the areas of:

- Heart disease
- Kidney disease
- Falls
- Peripheral neuropathy
- Weight loss
- Unexplained behavioural changes

Competency assessments for registered nurses administering insulin to consumers with a diagnosis of Diabetes Mellitus form an integral part of organisational clinical governance.

Routine Observations

Routine observations are objective measures for clinical decision making and provide baseline data for residents in order to identify deviations that are indicators for a range of physiological changes with unplanned clinical outcomes.

These include:

- Infections
- Functional decline
- Deterioration
- Cardiac changes
- Myocardial Infarction
- Cardiovascular Accident
- Orthostatic hypotension
- Sepsis

A need for further investigation is triggered by changes in routine observations.

In this context routine observations include:

- Blood pressure measurements and recording
- Temperature measurements and recording
- Respiration rate measurements and recording
- Pulse rate measurements and recording
- Any regularly occurring pathology tests

In this domain, between 2017 and 2019, there was a decline in:

- Compliance with medical officers' orders of 2.5%
- Initiating and documenting actions if observations were outside the normal range of 3.2%
- Amending care and services plans accordingly (2.7%)

Improvements occurred in the clinical management of care planning (1.5%) and care plan review (1.7%).

Bowel Charts

Bowel charting provides critical clinical information in relation to overall consumer quality of care and services delivery.

In particular, the identification of constipation or diarrhoea through the use of a bowel chart indicates a need for further investigation and a care and services plan review. An increase in the number and a change in the characteristics of a consumer's stool may be a lead clinical indicator for an infection such as gastro-enteritis.

The clinical information contained in the bowel chart enhances continuity of care and can be used as an integral contributor to the clinical handover process.

Chronic constipation and faecal impaction lead to unplanned preventable transfers to the acute care sector. If left untreated sepsis may result and lead to premature death.

Constipation causes:

- Urinary retention that can cause a urinary tract infection
- Delirium
- Bowel obstruction
- Anorexia leading to weight loss
- Nausea and vomiting
- Abdominal pain
- Unexplained changes in behaviour
- Sepsis and death

The QPS Benchmarking data for Bowel Charting between 2017 and 2019 indicated there were improvements in the clinical management of bowel charting. In particular there were improvements of:

- 4% in daily bowel charting record keeping
- 3% in the identification of timeframes outside of accepted ranges
- 4% in the area of care plan management
- 4.5% in resident observation documentation within their care plan and monitoring and documentation according to the care plan

A small decrease in the area of bowel chart coding of 0.8% occurred.

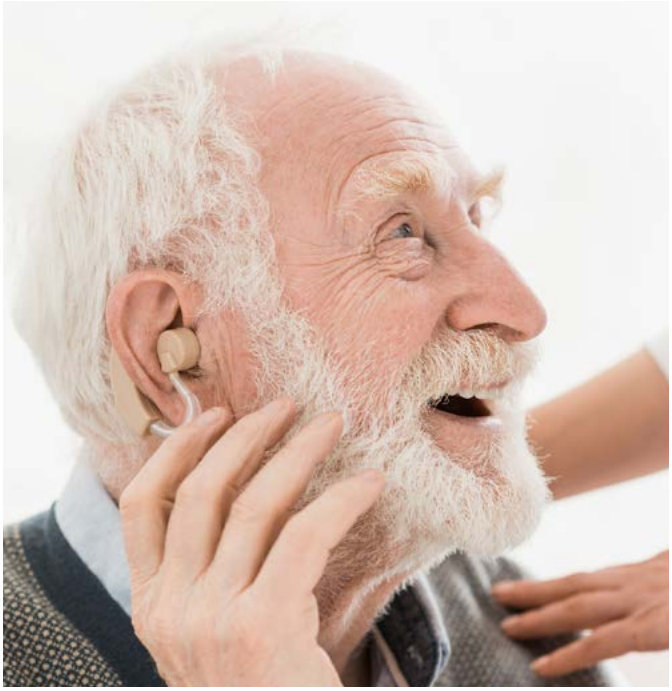
Sensory Loss

The QPS Benchmarking in the area of sensory loss identifies changes in measurement for sight, hearing, touch, smell, taste and speech.

Sensory loss is an important care consideration as it impacts the quality of life of a resident living in residential aged care. Sensory loss impacts:

- Wellbeing
- Communication
- Social connectedness
- Routine care and services delivery
- Personal safety in day to day activities (increased risk of falls)
- Appetite
- Weight loss

The QPS Benchmarking data in the area of sensory loss identified a decrease in clinical governance in the area of sensory assessment on admission of 1.5%.



Improvements in clinical governance in the area of vision were increased visits from an optometrist or optical technician (6%) and correct wearing and cleaning of glasses (3%).

The following improvements in clinical governance in the area of hearing were measured:

- 9.5% in regular monitoring by an audiologist
- 1% in the correct application and cleaning of hearing aids

There was a 2.3% decline in care plan management in this domain.

There was an increase in the recognition of tactile sensory changes of 3%.

Speech pathology monitoring scored a 10.65% improvement. Care planning to reflect any identified speech interventions improved by 2.2%, whilst identification of any deficits such as an inability to smell food or changes to a resident's appetite improved by 2.6%.

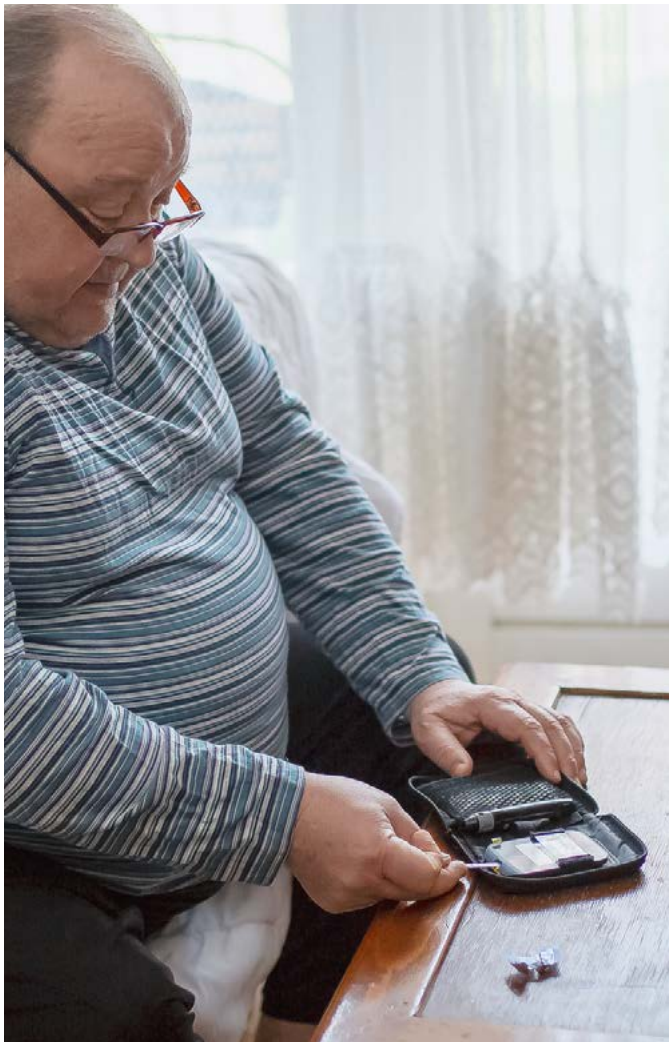
Specialised Needs

QPS Benchmarking in the area of Specialised Needs includes:

- Podiatry for residents with diabetes or vascular disease
- Speech pathologist for residents with a suspected swallowing difficulty
- Residents with urinary catheters, including supra-pubic catheters
- Occupational Therapy or Physiotherapy for residents with mobility and dexterity issues

These specialist clinicians are members of the multidisciplinary care team.

These areas that they cover are indicative of high impact clinical risk and have also been identified as such by the HiRA-E Clinical assessment tool (Anchor Excellence 2020).



Podiatry

In the area of podiatry visits by a podiatrist declined by 2%. Care planning to reflect any identified podiatry interventions declined by 1% and care plan reviews by 3.3%.

Podiatry services support best-practice foot hygiene and care and this reduces the risk of falls. Falls and the consequences of falls represents the highest cause of preventable death in residential aged care.

Choking

Choking is the second leading cause of preventable death in residential aged care (Anchor Excellence 2019). Swallowing difficulties are a lead clinical indicator for:

- Aspiration of food and fluids
- Reluctance to drink and eat
- Unplanned weight loss
- Choking
- Death

For residents with a suspected swallowing defect, assessment by a speech pathologist increased by 8.7%.

Decreased scores were identified in:

- The use of thickened fluids (1%)
- Staff education concerning fluid thickness and preparation (5.2%)
- Care plan review (1.5%)

Catheter Care

In the area of catheter care there was a decline of 4% in compliance with monitoring the supra-pubic catheter care site. The monitoring for the presence of infection at a catheter site declined by 3% as did the recording of the date due for the next catheter change.

There was also a decrease of 3% in care planning to reflect any identified interventions. A 2% decrease was identified in care and services plan review.

This is significant because of the risk of infection associated with a urinary catheter.

Infections associated with a urinary catheter cause:

- Unplanned transfer to hospital
- Changes to routine observations
- Disruption of blood glucose levels
- Sepsis
- Death

Therapy

In the area of Occupational Therapy or Physiotherapy for residents with mobility and dexterity issues measures were stable between 2017-2019. There was a decrease of less than 1% in the areas of:

- Referral to an occupational therapist or physiotherapist
- Care planning to reflect any identified interventions
- Care plan and services plan review

Palliative Care

Consumers are living longer with chronic illnesses such as osteoarthritis and cancer. On admission to residential aged care, consumers are older, sicker and frailer with many requiring palliative care.

The QPS benchmarking data collection in the domain of palliative care has two (2) foci-Palliative Care and Palliative Care for residents with Advanced Dementia.

Regular palliative care education for the aged care team and residents, as well as their families in relation to end of life care and advance care planning remained stable; whilst, there was a 2.3% decrease in staff receiving palliative care education or having access to a palliative care consultant.

The specialised care area of palliative care planning identified significant improvements in all QPS Benchmarking auditing criteria with the exception of regular education programs for employees and families on issues about end-of-life care and advance care plans. This is tabulated on the next page.

For Residents Receiving Palliative Care

AREA	IMPROVEMENT (%)
Has codesigned advance care planning occurred?	8.5
Has regular detailed assessment and review to establish as far as possible resident's goals and priorities for treatment occurred?	7
Was there compliance with resident preferences , including acceptance or refusal of certain treatments and medications?	8
Where residents Specific comfort needs acknowledged	6
Was there a pain control plan with evidence the resident is pain free?	8
Is there an End of Life Care Plan	19
Is there post death family support and referral in place?	8

For Residents Receiving Palliative Care with Advanced Dementia

AREA	IMPROVEMENT (%)
Use of Pain Assessment in Advanced Dementia Scale (PAINAID) for pain and discomfort management	29
Evidence hospitalisation was avoided	9
Evidence restraint use avoided	14
Social connectedness assessment	22

QPS BENCHMARKING MEDICATION AUDITS

The Residential care sector performance data (2019) lists medication management as the most frequent complaint received by the Aged Care Quality and Safety Commission*. These complaints account for 16% of all complaints received between July and September in 2019.

This suite of QPS Benchmarking Medication Audits cover three (3) areas related to medication management. These are staff responsibilities, medical officer responsibilities and Schedule 8 medication management.

These audits are aligned to the following Aged Care Quality Standards*:

Aged Care Quality Standard 1

Consumer dignity and choice

Provides an avenue for consumers to self-medicate.

Aged Care Quality Standard 3

Personal and clinical care

Particularly requires the 'Effective management of high-impact or high-prevalence risks associated with the care of the consumer' (2019).

The purpose of these audits is to assist care staff to monitor the processes and practices to manage medications in residential aged care. These audits also intend to improve consumer safety by reducing the risk of adverse medication events.

This suite of audits aims to:

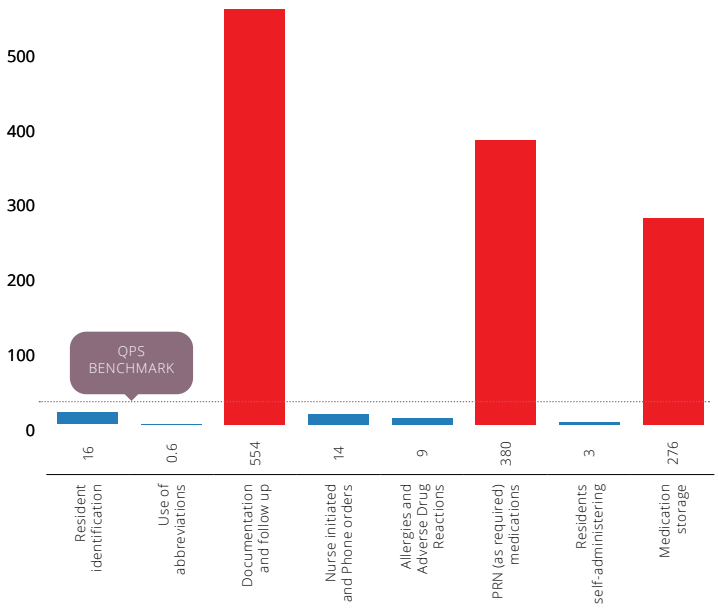
- Improve the safety and quality of medication management
- Evaluate the safety and quality of prescribing, administration and related medication management and documentation processes
- Identify continuous improvement in medication delivery systems

** Australian Government 2019*
Aged Care Quality and Safety Commission 2019

QPS BENCHMARKING MEDICATION AUDIT - ERROR RATE

QPS Benchmarking Medication Audit-Staff Responsibilities

The following graph demonstrates the domains performing above and below the QPS benchmark.



The following areas of concern were identified:

- Documentation to reflect the refusal of or withholding of a medication (and subsequent review of this)
- Monitoring of the medication's efficacy
- PRN (as required) medication regimen protocols
- Documentation regarding the efficacy of PRN medication use
- Review of PRN medications
- Maintenance of the refrigerated medication storage areas (defrosting and temperature monitoring)
- Delays in discarding medications
- Use of expired eye drops and ointments
- Medication storage mix

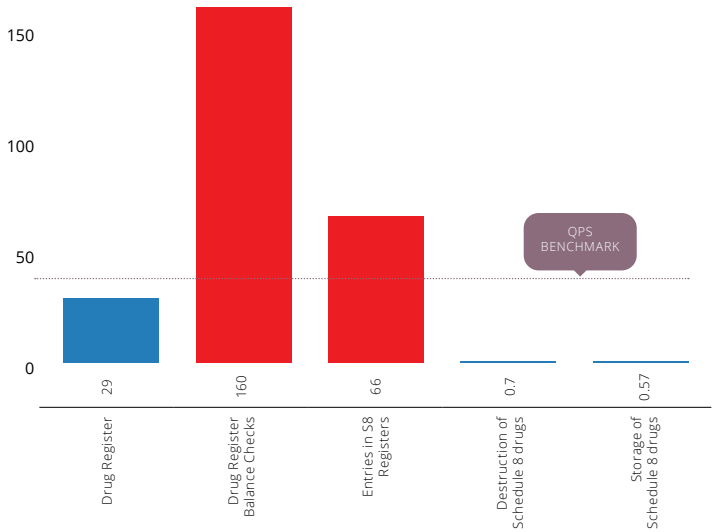
These areas of concern highlight the need for more rigorous clinical governance in this area of clinical care. Avoidable consequences of medication mismanagement include:

- Gastro-intestinal upsets such as nausea, vomiting and diarrhoea
- Adverse drug reactions that can lead to unplanned transfer to the acute sector
- Death

**Note the QPS benchmark is an indicator derived by calculating the weighted mean. It is specific to each audit. Details are outlined QPS Benchmarking Methodology.*

QPS Benchmarking Medication Audit S8 Drugs

The following graph demonstrates the domains performing above and below the QPS benchmark.



These results paint a picture of general non-compliance with clinical governance related to Schedule 8 medication management. Of particular significance are the following areas of concern:

- Non-compliance with Schedule 8 Register balance checking protocols, in particular failing to record the date and time a Schedule 8 medication was given to a resident and Schedule 8 balance checks between shifts
- Non-compliance with documentation in the Schedule 8 Register, in particular:
  - The time the drug was administered
  - The name of the prescriber
  - Making changes in the Schedule 8 Register by altering or obliterating writing
  - Failure to correct errors according to protocols

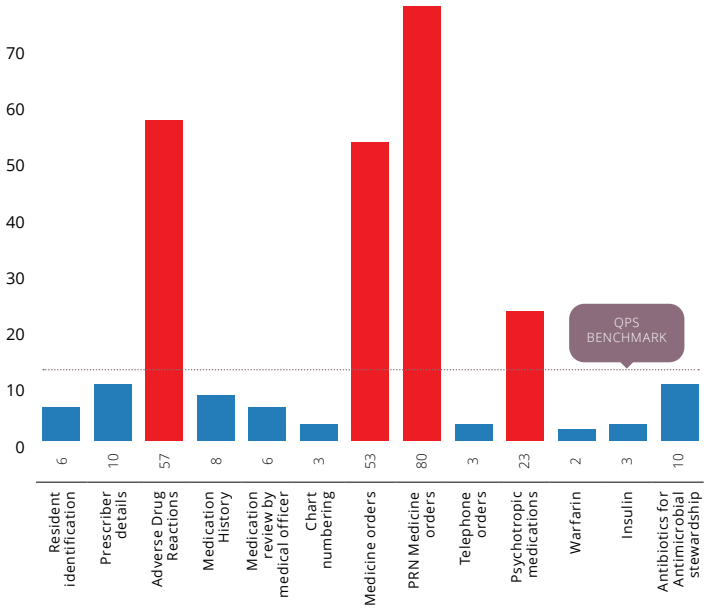
Failure to comply with protocols based on legislation and regulation that relate to the management of Schedule 8 medications can have significant consequences for both the consumer and the nurse.

One serious consequence of this failure to comply with protocols based on legislation and regulation is reporting the nurse to registering authorities for investigation, which could lead to restrictions of practice or deregistration.

**Note the QPS benchmark is an indicator derived by calculating the weighted mean. It is specific to each audit. Details are outlined QPS Benchmarking Methodology.*

QPS Benchmarking Medication Audit-Medical Officer Responsibilities

The following table demonstrates the domains performing above and below the QPS benchmark.



These results paint a picture of general non-compliance with clinical governance related to the compliance by medical officers for medication management.

Of particular significance are the following areas of concern:

- Allergies and previous/current adverse medication reactions not identified
- Medication orders:
  - Not clearly written
  - Route of administration not completed
  - Prescribers name illegible
  - Ceased medication orders not documented, signed and dated by medical officer
  - Maximum PRN dose in a 24-hour period not documented
  - Poor documentation for the use of psychotropic medications, in particular with no written consent

These areas of concern in this audit clearly place the consumer at risk and have a significant flow-on effect on the safe and quality management of medication in residential aged care.

The flow-on effect of this is reflected in the data from the Staff Responsibility and Schedule 8 management audits.

Taken together, this suite of audits reveals errors that relate directly to knowledge and skills deficits and protocol-based non-compliance.

Given the poly-pharmacy needs of the residents there is a need for greater surveillance in medication management.

Note the QPS benchmark is an indicator derived by calculating the weighted mean. It is specific to each audit. Details are outlined QPS Benchmarking Methodology.

This concludes the overview and analyses into the level of care and service provision in residential aged care in Australia between 2017 and 2019.

Section Five

Evidence Base

QPS BENCHMARKING

The following is a summary list of QPS Benchmarking Key Performance Indicators that were used to inform this report.

Aged Care Key Performance Indicator Model

Aged Care Quality Standards	Indicator Name
ACFI vs Care Staff Work Hours	
Standard 8	ACFI Funding
Standard 8	ACFI - ADL Score
Standard 8	ACFI - Behavioural Score
Standard 8	ACFI - Complex Needs Score
Standard 7	Care Staff Work Hours
Clinical - Quality of Care	
Clinical Outcomes:	
Standard 3 & 4	Unplanned Resident Transfers
Standard 3	Unplanned Weight Loss
Standard 3	Infections
Standard 3	*Pressure Injuries - Total* • *Pressure Injuries - Facility Acquired* • *Pressure Injuries - Externally Acquired*
Standard 3	*Falls - Total - General* • *Falls With Injury - General* • *Falls Without Injury - General*
Standard 3	Aggressive Episodes - General
Standard 3	Restraint Chemical - General

Standard 3	Restraint Physical - General
Standard 3	*Falls - Total - Dementia Specific* • *Falls With Injury - Dementia Specific* • *Falls Without Injury - Dementia Specific*
Standard 3	Aggressive Episodes - Dementia Specific
Standard 3	Restraint Chemical - Dementia Specific
Standard 3	Restraint Physical - Dementia Specific
Clinical Audits:	
Standard 2 & 3	Quality of Care Audit
Standard 1 & 3	Medication Audit Staff Responsibilities
Standard 3	Medication Audit MO Responsibilities
Standard 3	Medication Audit S8 Drugs
Stakeholder Experience & Satisfaction Surveys	
Standard 1, 2, 3, 4, 5, 6, 7 & 8	Resident Experience Index • *Resident - Net Promoter Score*
Standard 1, 2, 3, 4, 5, 6, 7 & 8	Relatives Experience Index • *Relatives - Net Promoter Score*
Standard 1, 6, 7 & 8	Employee Satisfaction Index • *Employee - Net Promoter Score*

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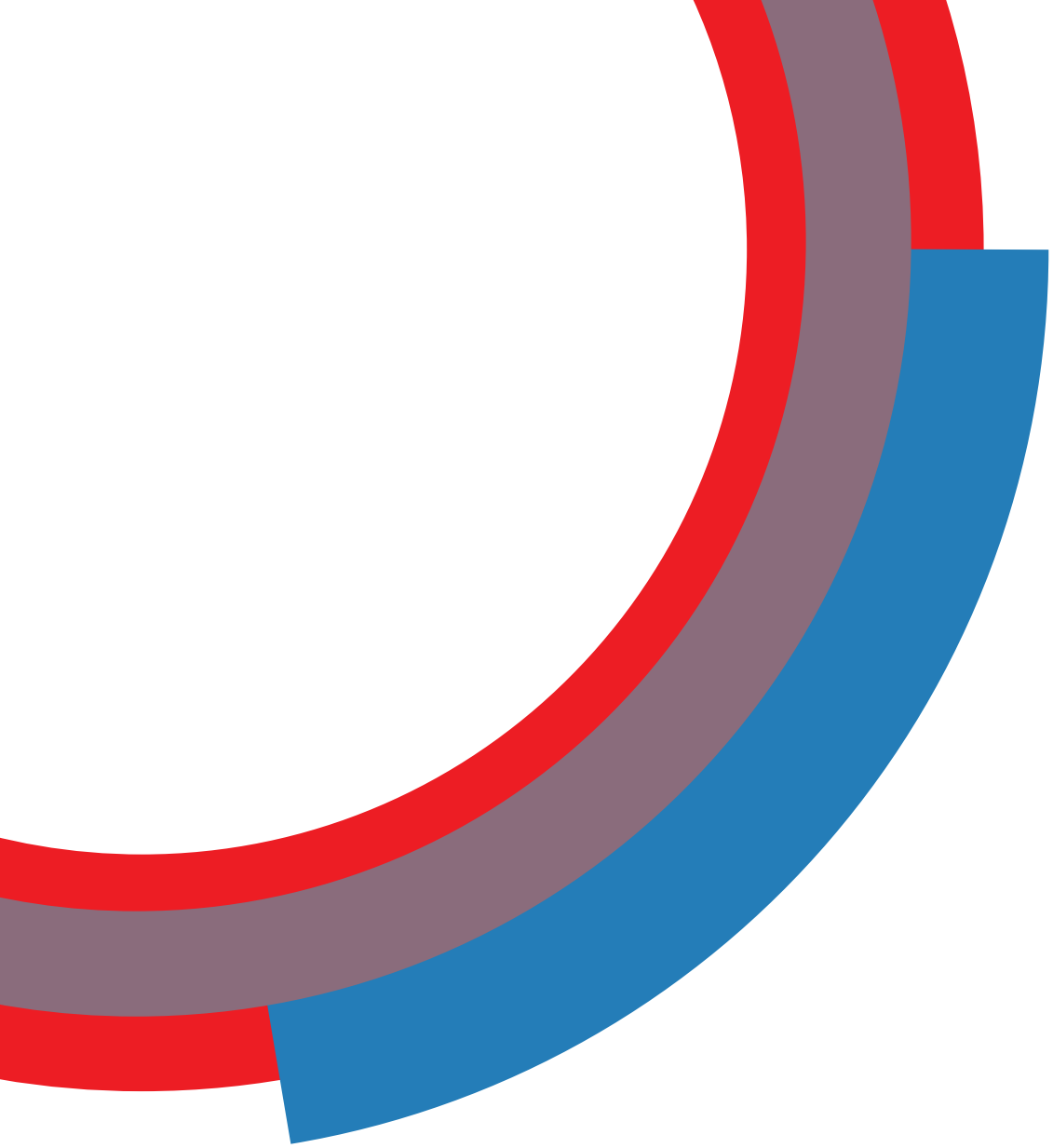

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