Aged Care Quality Indicator Program

A response from Dementia Australia

6 December 2019

About Dementia Australia

Dementia Australia (formerly known as Alzheimer's Australia) is the peak, non-profit organisation for people with dementia and their families and carers. We represent the more than 447,000 Australians living with dementia and the estimated 1.5 million Australians involved in their care.

Dementia Australia works with people impacted by dementia, all governments, and other key stakeholders to ensure that people with all forms of dementia, their families and carers are appropriately supported – at work, at home (including residential aged care) or in their local community.

Our close engagement with individuals and communities means that we are an important advocate for those impacted by dementia and we are also well placed to provide input on policy matters, identify service gaps and draw on our expertise to collaborate with a wide range of stakeholders, including researchers, technology experts and providers.

In addition to advocating for the needs of people living with all types of dementia, and for their families and carers, Dementia Australia provides support services, education and information aimed at addressing the gaps in mainstream services.

Dementia Australia is a member of Alzheimer's Disease International, the umbrella organisation of dementia associations around the world.

dementia australia™

Section 1 Pressure injuries

1. **Any other comments or feedback on the existing or potential QI measures?**

In addition to recording the occurrence and type of pressure injury sustained, it would also be useful to ensure that any related health conditions are recorded, for example if the resident has dementia and if the resident is taking any medications. Adding this information would create a richer understanding of why and how pressure injuries may occur, and who they are occurring to.

Section 2: Physical restraint

2. **What are the advantages and disadvantages of the current use of physical restraint QIs, considering the current definition against the program objectives?**

The current quality indicators for physical restraint, including reporting on the intent to use a restraint and the type of restraint used, aims to provide transparency around the regularity of restraint use and the types of devices used by aged care facilities. This marks a positive step forward in improving the quality of care delivered in residential aged care facilities.

One of the pertinent issues for people living with dementia is the use of physical restraints to manage behavioural and psychological symptoms of dementia (BPSD). Whilst the intent of a provider may be to keep a resident safe, the use of a restraint should always be a method of last resort. A strong body of evidence supports that there are a range of effective strategies and non-pharmacological interventions that can reduce the need for restraints. These strategies largely look at the underlying causes of behaviours – such as environmental stressors, which may be causing a particular response.

Currently, the Quality Indicators for physical restraints do not directly address the issue of appropriateness of restraint use, or if a provider has employed other strategies to support an individual, before applying a restraint.

The solution to this may be to ensure that providers use the comment box to provide contextual information around the decision to use a restraint. Providing exemplars or standardised responses may also be welcomed and reduce the burden on staff reporting. For example; ‘the restraint was at the request of a resident’ or ‘restraint used at mealtimes only’.

Additionally, the current definition does not capture the outcome for the resident if restraints have been used. Dementia Australia believes that additional information needs to be recorded that captures resident outcomes of restraint use. Particularly, how has the restraint impacted the behaviour of the person; affected their quality of life and/or impacted on their human right to freedom of movement. In the case of people with dementia, as noted above, physical and/or chemical restraints are often administered before behaviour management strategies have been tried. It is important that the Quality Indicators capture the impact that restraints have on the person.

3. **Consider which QI provides a more meaningful measure: people physically restrained, physical restraint devices used, intent to restrain, or a combination of these?**

Whilst reporting on the prevalence of restraint use is crucial to improving transparency and reducing the overall use of restraints, it is also important that the Quality Indicators tease out instances where restraints are being used inappropriately. For example; a resident requesting bed rails to prevent falls at night is a functional use of restraint, and vastly different to instances where residents have been restrained for excessive periods of time during the day because staff are particularly busy. Inappropriate use of restraint can refer to a number of issues, such as;

- A restraint used for an excessive amount of time
- Restraint use on an individual who does not require a restraint for their safety or if an alternative method could be used
- If informed consent, to use a particular restraint device over a particular period of time, has not been obtained.
- If the restraint causes physical or psychological injury to an individual
- If a restraint is used before the aged care facility has exhausted other options to manage an individual's behaviour.
- If restraints are not monitored appropriately by staff, to ensure a residents' safety

Therefore, a preferred approach is to combine the intent to use a restraint with the type of restraint used and the length of time the individual was in the restraint.

Reporting on injuries caused by restraint use; such as falls caused by an individual trying to get out of a restraint, decline in mobility and psychological impacts of being restrained, could also be considered as additional indicators helping to mitigate inappropriate use of restraints.

4. **What are the implementation barriers and enablers?**

A clear articulation of what constitutes an 'inappropriate' and 'appropriate' use of physical restraints would be an enabler for providers and should accompany the Quality Indicators. Clear guidelines, which are recognised by all providers would increase understanding about how to report accurately, but also increase staff understanding around when a restraint may be used, for how long and what monitoring procedures need to be in place.

The Indicators program would also need to be linked to the Serious Incident Response Scheme or other compliance processes (e.g. state/territory legislation).

5. **What are your views on if and how secure areas might be reported as part of a QI? Secure areas are currently excluded from the use of physical restraint QI, but could these be included or reported as a separate measure in the QI instead?**

People with a lived experience of dementia have different perspectives on the appropriateness of secure areas and whether they should be defined as a form of restraint. However, it would be useful to collect information on secure area use because it will contribute to the bigger picture of how care is delivered, the impact that a secure area might have on other quality indicators and give comparative data on the impact of a secure unit versus an open facility.

6. **How often should the use of physical restraint be assessed each quarter (e.g. weekly, monthly or quarterly)?**

Recognising the potential time and resource constraints involved in regular reporting, generally more regular assessments create for better overall recording and monitoring of restraint use. Weekly restraint recording is more likely to reduce the inappropriate use of restraints, due to increased monitoring behaviours.

Section 3: Unplanned weight loss

7. **What are the advantages and disadvantages of the current unplanned weight loss QIs, considering current definition against the program objectives**
8. **Could a focus on kilograms, percentage weight loss, Body Mass Index or malnutrition risk be more useful?**

Malnutrition is a significant concern for people living with dementia. Poor nutrition can have significant impacts on cognitive function, contribute to the development of delirium and lead to rapid declines in mental state and changes in behaviour.

Weight loss, due to undernourishment is common amongst people with dementia and can increase the risk of hospitalisation, institutionalisation and mortality. According to Alzheimer's Disease International (2014), studies indicate that up to half of people with dementia in residential age care experience clinically significant weight loss over one year.

Currently almost half of the residents in aged care facilities have a diagnosis of dementia. Supporting people with dementia living in residential aged care to remain well-nourished and avoid malnutrition is a key priority and therefore should be considered in developing the unplanned weight loss QI. Further, the weight loss QI may also note that individuals who may have an underlying condition that links to poor nutrition and weight loss – such as dementia – should be reported on to avoid undernourishment that leads to weight loss.

Section 4: Falls and fractures

9. **What are the possible advantages and disadvantages of the identified falls and fractures QIs, specifically in relation to the QI Program objectives?**

Falls and their associated injuries are a significant contributor to the overall physical health and psychological wellbeing of residents within aged care. Recurring falls, which occur in 40 percent of residents who have had a fall in an aged care setting, can create a significant risk to resident's health, evidencing why providers should actively mitigate against falls in aged care and report on their occurrence.

There are also potential benefits to reporting on process measures. For example, the indicators adopted in the UK, highlight how many residents in a facility may be at risk of falling, and what measures are in place to prevent falls from occurring – for example mobility aids being within reach of a resident. If process reporting is used effectively, providers may be able to utilise the information to determine which residents are most at risk and require more regular monitoring to prevent avoidable falls.

10. **Which is a more meaningful indicator – measuring total number of falls, or people who fall?**

Recording the prevalence of falls is important, and could provide insights into the fall management and mitigation measures of an aged care facility. However, simply measuring the total number of falls per aged care facility, could easily be skewed by a select number of individuals who may have more regular falls. A more robust measure would consider the percentage of total care recipients who had falls, and how regular those falls have occurred.

11. **Should major injuries (beyond fracture, e.g. dislocation or head injury) be captured under the falls and fractures QI?**

Any major injury caused by a fall should be captured by the falls and fractures QI. Major injuries can have lasting health and psychological ramifications to residents, and reporting these incidents is important to ensure residents are safe in their environment. Transparency around major injuries and falls is also critical to the learning and improvement of aged care facilities. Providers should be encouraged to use this data to ensure facilities are reducing any falls risks, and providing safe living environments to residents.

In developing the falls and fractures QI, it is important to consider the variation in severity and impact of falls. It is important that minor falls – which have had no significant impact are delineated from major incidents.

12. **Should additional process measures (identified in the Tier 2 measures from the UK) be considered for collection and should these be optional or mandatory**

The UK's process measures for falls and fractures, are useful indicators to demonstrate a provider's preparedness and quality of practice with regards to preventing falls. In particular, proactively identifying residents who may have a higher risk of falls – for example, due to medications that may put them a higher risk of falling – and ensuring mitigations are in place, may prevent avoidable falls from occurring.

Easy to measure, process indicators, such as 'resident has reachable access to mobility aids' and 'easy access to call out bells' also helps to monitor those who may be at risk of falling and potentially prevent falls.

A key implementation consideration for including process measures, is the staff time required and feasibility of reporting on regular processes. Reporting on these QI's must be balanced with the workload of staff, and not create overly burdensome paperwork which detracts from caring responsibilities.

Section 5: Medication Management

13. **Which of the four key medication management QI categories ('chemical restraint', polypharmacy, medication errors or other medication related QIs) could best support the QI program objectives?**

The inappropriate use of chemical restraints and the occurrence of medical errors in aged care are particularly indicative of the quality of medication management, and such, indicative of high quality care.

Chemical Restraint QI

Inappropriate use of anti-psychotic medications, or 'chemical restraint', is a common and significant concern raised throughout the aged care sector. The use of anti-psychotics is of a particular concern of people living with dementia, who are often prescribed medications to manage behavioral and psychological symptoms of dementia. A strong body of evidence supports that not only is there a significant overuse of chemical restraints in aged care, but there is minimal evidence to support their effectiveness in managing behavioral and psychological symptoms of dementia. Reporting on the inappropriate use of chemical restraints to manage behavior should be a key consideration for the Quality Indicator program.

To ensure the safety of the resident through this QI, information needs to be recorded that demonstrates a Behavioural Support Plan is integrated into care before prescription and/or administration occurs. Before 'administering' the drug, aged care providers need to have

confirmed with the prescriber that informed consent was received from the Consumer or the Consumer's representative. A report via the 'Serious Incident Reporting Scheme' will occur if any physical or chemical restraint occurs (i.e. where it is not for therapeutic usage) where:

- No Behavioural Support Plan has been agreed with the person and/or their nominated representative by the time of prescription;
- Informed consent has not been received or confirmed prior to the time of administration.

The QI on chemical restraint should mandate an administration register which records all usage of 'chemical restraint' (with immediate effect). This could be introduced through a register to be held by all Aged Care Providers that records each administration of a medication or chemical substance administered as a 'chemical restraint' (as defined in the current regulations) in a similar manner to Schedule 4D and Schedule 8 drugs.

Approved Provider staff administrating antipsychotic or other medication for the purpose of chemical restraint should be required to record at a minimum (but not limited to):

a) confirmation by the approved provider staff that has or has not received "informed consent" (and from whom) prior to administration,

b) if the administration occurred under a once only, PRN (as required) or ongoing prescription basis

c) confirm if a behavioural management plan was in place and acted upon

The register should mandatorily be made available for external scrutiny by the Aged Care Quality and Safety Commission.

Furthermore, a comprehensive medication review should occur if prolonged usage has been demonstrated, including identification of frequent or inappropriate use of PRN antipsychotic.

The QI should also ensure medications are recorded on the register as being destroyed upon the Consumer's death or at such time that a prescriber discontinues the prescription or its usage.

Medication Error QI

Similarly, medical errors in aged care should also be considered as a measure of quality care. Whether a medical error has caused a significant impact or minimal impact to the resident, transparency around medical errors should be encouraged, to prevent errors re-occurring and to ensure accountability where mistakes are made. An important consideration for this indicator is how to allow for accurate accountability reporting – especially in instances where medical errors may occur outside of the aged care facility, such as in hospital just before re-entering the aged care facility.

Finally, whilst evidence supports that polypharmacy can increase risks to health, there are also substantial risks involved if an individual is prescribed just one inappropriate medication. Good medication management should centre on the appropriateness of medications in safely supporting an individual's personal care needs and preferences.

14. What are the possible advantages and disadvantages of the identified medication management QIs?

The key advantages of reporting on medical errors in aged care and the inappropriate use of chemical restraints, is improved transparency around the use of medications and improved

monitoring of how and when medications are used. Not only does this provide reassurance to care recipients, but it improves accountability and encourages high quality medication management.

With closer monitoring around the use of medications, providers may be deterred from using medications as a first response, and encouraged to consider non-pharmacological approaches to manage behavioral and psychological symptoms of dementia – which also supports good practice.

15. **What are the perceived implementation enablers and barriers of your preferred medication management QI?**

A key implementation barrier to reporting on chemical restraints is the understanding of what constitutes an 'inappropriate use' of chemical restraints'. In most cases, the intent of prescribing a chemical restraint will be to reduce agitation or to calm an individual – which may be viewed as being in the best interest of the resident and not inappropriate. Therefore, clear guidelines and definitions need to be produced, and articulated to ensure there is an agreed understanding on when a restraint is considered appropriate or inappropriate.