Submission by the Australian Nursing and Midwifery Federation

Review of the National Aged Care Quality Indicator Program

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Australian Nursing & Midwifery Federation

Annie Butler
Federal Secretary

Catelyn Richards
Federal Assistant Secretary

Alana Ginnivan
Assistant to the Federal Secretary (Strategy & Campaigns)

Australian Nursing and Midwifery Federation
Level 1, 365 Queen Street, Melbourne VIC 3000
E: anmffederal@anmf.org.au
W: www.anmf.org.au

1. About this submission

The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest professional and industrial organisation for nurses, midwives and care workers in Australia, with more than 356,000 members nationally. A substantial proportion of our members work in residential aged care.

ANMF welcomes the opportunity to comment on the proposed enhancements to four quality indicators: incontinence care, hospitalisation, activities of daily living, and workforce. This submission responds to each of the twelve proposed enhancements, sets out conditions attaching to those we support, and proposes four additional measures for the Department's consideration.

The positions in this submission have been developed through consultation with ANMF branches and reflect the direct experience of registered nurses, enrolled nurses and care workers delivering care in residential aged care homes.

The Quality Indicator Program currently measures harm events: falls, pressure injuries, incontinence associated dermatitis, and hospital transfers. It contains a single workforce measure. It does not measure whether a residential aged care home is staffed and resourced to prevent the harm it counts. Several of the proposed enhancements begin to close that gap, and ANMF supports them for that reason. Two would reduce what the data makes visible, and ANMF does not support those as proposed.

2.Summary of ANMF positions

Ref	Proposed enhancement	ANMF position
I 1	Additional reporting for new cases of IAD acquired in the home	Support, with conditions. ANMF proposes an alternative construction at section 9.
I 2	New quality indicator for residents who develop incontinence after admission	Support in principle, with substantial conditions. Must distinguish preventable from non-preventable causes.
I 3	Additional reporting for IAD acquired before admission	Support, with conditions. Depends on an assessment requirement within 7 days of admission.
H 1	Remove the ED presentations or hospital admissions data point	Support, with one condition. Visibility of admissions that bypass the emergency department should be retained in additional reporting.
H 2	Additional reporting for ED presentations via technology enabled platforms	Support, with conditions. The term technology enabled platform must first be defined. See section 8.
H 3	New data point: ED presentations per 1,000 occupied bed days	Support, with conditions on risk adjustment, small service volatility, and stated program intent.
A 1	Raise the decline threshold from 1 point to 2 points on the Barthel Index	Not supported as proposed. ANMF proposes reporting both thresholds.
A 2	Additional reporting for decline in early loss ADL items	Support, with conditions. ANMF questions the inclusion of stair climbing in the early loss group.
A 3	Additional reporting for residents who improve after admission	Support.
W 1	New reporting of the share of direct care hours delivered by agency staff	Support, conditional on parallel reporting of hours worked above contracted hours by directly employed staff.
W 2	Replace the existing staff turnover measure	Support, with conditions. Should be adopted together with W 1.
W 3	Rename the workforce domain to continuity of care	Not supported.

3. General observations

The following apply to every enhancement ANMF supports and are not repeated under each item.

3.1 Data capture must be system generated

Wherever an enhancement proceeds, the data must be captured through care management software, with vendor engagement and funded implementation and consultation with the workforce. It must not rely on manual counting or on retrieval from progress notes. The review itself records that some information is currently obtained by searching clinical records by hand. Time spent searching records is time not spent delivering care, and it falls disproportionately on registered nurses. ANMF regards automated capture as a condition of support for every enhancement in this submission.

3.2 Risk adjustment must precede publication or comparison

Several of the proposed measures will produce volatile results in smaller services, where a single resident can move a reported figure substantially. Several will disadvantage services with higher acuity, palliative and dementia populations. ANMF asks that no new or revised measure be published, benchmarked between services, or incorporated into Star Ratings until risk adjustment is in place. We note risk adjustment is proceeding as a separate program of work and ask that these enhancements be sequenced accordingly.

3.3 Changes to a published measure require parallel reporting

Changes to the definition, threshold, or calculation of a published measure create a break in the national time series. As a result, reported performance may change even where there has been no change in the care provided. ANMF recommends that, whenever a measure is revised, the old and new methodologies be reported in parallel for at least four reporting quarters. The Department should also clearly state that any change in results at the point of transition reflects a change in measurement methodology rather than a change in care quality.

3.4 The absence of a service should be visible in the data

Access to hospital avoidance services, including virtual emergency departments, hospital in the home and geriatric outreach, is funded by states and territories and is unevenly available. A residential aged care home without access to these services will record outcomes that look worse than a home that has them, with no difference in the quality of nursing care provided. ANMF asks that the data collection include a field recording where a relevant service is not available in the home's locality, so that absence of a service is distinguishable from non-use of one.

3.5 Program guidance should state intent and protect clinical judgement

Where an indicator counts clinical escalations, program guidance should state explicitly that the objective is to reduce avoidable events rather than events as such and should make clear that clinical judgement to escalate is supported. Without that statement, an indicator that rewards a lower number creates pressure to delay a necessary escalation. That is a patient safety risk, and

it falls on the nurse making the decision at the bedside, frequently at night and frequently without medical support on site.

3.6 Several measures will be read as measures of staffing

Several of the proposed enhancements will, in practice, reflect whether a home has sufficient nursing and care staff to deliver the care the measure assumes. ANMF submits this is a strength rather than a weakness, provided the results are interpreted accordingly. We ask that the Department read these measures as information about workforce capacity and resourcing, and not as a measure of the performance of individual clinicians.

4. Incontinence care quality indicator

4.1 I 1 Additional reporting for new cases of IAD acquired in the home

> **ANMF position: Support, with conditions.**

- Incontinence associated dermatitis is substantially preventable, and prevention relies on care staff having sufficient time and resources to undertake frequent checking, prompt changing, application of barrier products, and skin inspection. A measure focused on new cases would encourage investment in preventative care and direct attention toward prevention and early intervention, rather than reactive treatment once skin damage has occurred.
- The existing construction counts cases that persist across reporting periods despite appropriate care, including cases arising from conditions such as bowel malignancy or persistent diarrhoea. These obscure what is occurring in the current period.

Conditions

- A clear and tightly specified definition of what constitutes a new case, to avoid inconsistent application between services.
- Acknowledgement in program guidance of the statistical limitations arising from low prevalence, particularly in smaller services.
- System generated capture, consistent with section 3.1.

ANMF proposes an alternative construction that would deliver this information more efficiently. See section 9.1.

4.2 I 2 New quality indicators for residents who develop incontinence after admission

ANMF position: Support in principle, with substantial conditions.

- ANMF supports the intent of the measure. Preventable loss of continence is a significant harm to a person's dignity, independence and functional capacity. It is not an inevitable consequence of ageing or of entering residential care, and its prevention should therefore be recognised as an important quality outcome.
- The review's own consultation findings support its inclusion. Expert evidence indicated that some residents enter residential aged care continent and become incontinent shortly afterwards, with this decline attributed to staffing constraints and a consequent reliance on continence aids. This is consistent with our members experiences. Assisting a resident to the toilet can take between 7 and 22 minutes, depending on their level of dependence, and many aged care homes do not have sufficient staffing to consistently provide this support..When residents are instead encouraged to rely on continence products, avoidable functional decline can occur.
- ANMF also notes continuing reports of continence aids being rationed, notwithstanding that the Aged Care Quality Standards do not permit this.

Conditions

- The measure must distinguish preventable from non-preventable loss of continence. Specifically, it must exclude or separately identify:
  - transient incontinence associated with relocation, disorientation and disruption to established routine in the period immediately following admission
  - reversible clinical causes, including urinary tract infection, constipation and medication effects
  - pre-existing incontinence that was not disclosed at the point of admission and is identified subsequently as a resident becomes more reliant on staff for personal care
- Environmental and built environment factors must be recorded, including the number and proximity of accessible toilets to communal areas. Where residents must queue for a toilet, or

where toilets are remote from where residents spend their day, the resulting loss of continence is a design problem and should not be recorded as a care failure.

- Baseline continence status must be established using a validated instrument. ANMF shares the concern raised in consultation that the existing assessment arrangements are not fit for this purpose.
- A continence assessment within 7 days of admission is additional clinical assessment, at the busiest and most resource intensive stage of a resident's care journey. To be implemented effectively and sustainably, it must be funded and supported through care management software capable of capturing and reporting the required data.
- The measure must not be published, used for benchmarking purposes or incorporated into Star Ratings until the pilot data collection has validated the proposed exclusions and demonstrated that the measure is reliable, comparable and fit for purpose.

ANMF proposes a complementary measure at section 9.2.

4.3 I 3 Additional reporting for IAD acquired before admission

> **ANMF position: Support, with conditions.**

- Residents frequently arrive from hospital or the community with existing skin damage or compromised skin integrity. Attributing these existing conditions damage to the receiving home would not accurately reflect the quality of care provided.
- ANMF supports retaining externally acquired cases within the total indicator while reporting them separately, so that overall management remains visible.

Conditions

- The enhancement depends on a skin assessment being completed within 7 days of admission or readmission. Current practice ranges from 1 to 90 days, averaging 45 days. A case cannot reliably be identified as externally acquired when the first assessment occurs six weeks after entry.
- That assessment requirement is new work and must be resourced and system supported.

5. Hospitalisation quality indicator

5.1 H 1 Remove the ED presentations or hospital admissions data point

ANMF position: Support, with one condition.

- ANMF accepts that the second data point adds limited insight. Approximately 3 per cent of residents are admitted to hospital without presenting to an emergency department, and the two measures track closely.
- Removing it reduces reporting work with little loss of information, consistent with the objective of containing burden.

Condition

- Visibility of admissions that bypass the emergency department should not be lost entirely. Direct admissions arranged by a general practitioner, and admissions to hospital in the home, are precisely the hospital avoidance pathways the program should be encouraging. ANMF asks that these be captured through additional reporting rather than removed from the collection altogether.

5.2 H 2 Additional reporting for ED presentations via technology enabled platforms

ANMF position: Support, with conditions. The definition must be settled first.

- ANMF strongly supports distinguishing virtual from physical presentations. These are materially different events for a resident. A virtual consultation that supports a resident to remain in their own bed, cared for by staff who know them, is a good outcome. A physical transfer means an ambulance, an extended period in an emergency department, disrupted medication and hydration, and a substantial risk of delirium, deconditioning and functional decline that does not fully reverse. For residents living with dementia the risk is greater again.
- ANMF supports retaining virtual presentations within the total indicator while reporting them separately. A virtual contact remains an escalation of care and still conveys information about clinical capability in the home. Excluding them would make the data incomplete and would disadvantage homes without access to these services.

Conditions

- The term technology enabled platform must be defined before this enhancement proceeds. ANMF sets out a proposed definition at section 8.
- Capture must be system generated. Virtual contacts are presently recorded in many homes only within progress notes, and manual retrieval would impose a significant and recurring burden on nursing staff.
- The existing baseline is unreliable, as providers are not consistently aware that virtual presentations are reportable. Any increase in reported rates following this change should be interpreted as improved data capture rather than deteriorating care, and the Department should state this when the first results are published.
- Availability varies substantially by jurisdiction and between metropolitan and regional areas. Consistent with section 3.4, the collection should record where no virtual emergency department or hospital in the home service is available.

5.3 H 3 New data point: ED presentations per 1,000 occupied bed days

> **ANMF position: Support, with conditions.**

- The existing construction counts a resident once regardless of how many times they present. A resident who presents ten times in a quarter is recorded identically to a resident who presents once. This conceals precisely the pattern that most warrants clinical review, and repeat transfers are cumulatively damaging.
- Normalising to occupied bed days is the appropriate basis for comparison between services of different size.

Conditions

- Risk adjustment before publication or benchmarking, consistent with section 3.2. Without adjustment for acuity, palliative status and dementia, services caring for higher needs' residents will present as poorer performers.
- Program guidance should recognise that results in smaller services will be volatile, and that a small number of residents with unstable conditions can move the figure materially.

- The question of whether to count events or residents has also been raised for falls and pressure injuries. ANMF asks that it be resolved consistently across the program rather than indicator by indicator.
- Program guidance should state that the objective is fewer avoidable transfers, not fewer transfers, and should protect clinical judgement to transfer, consistent with section 3.5.

6. Activities of daily living quality indicator

6.1 A 1 Raise the decline threshold from 1 point to 2 points

ANMF position: Not supported as proposed. ANMF proposes reporting both thresholds.

- A decline of 1 point on the Barthel Index is not a trivial change. On several items it marks the transition from independence to requiring assistance: from eating independently to needing food cut up, or from managing the toilet alone to needing the help of another person. The review's own question to the technical advisory group acknowledges that a 1-point decline can represent a significant loss of independence.
- Many of these early losses need not become entrenched, as timely assistance, encouragement and reablement can prevent avoidable deterioration and improve functional outcomes. Removing them from the measure removes the signal at the point at which intervention is most effective and least costly.
- Raising the threshold will reduce reported decline across the sector without any change in the care delivered, creating a misleading impression of improved outcomes rather than reflecting a genuine improvement in care or resident wellbeing ANMF does not consider it appropriate for a national quality measure to record an improvement that has not occurred.
- The stated problem is assessor subjectivity and measurement variability. The appropriate remedy for inconsistent assessment is standardised assessor training, clearer guidance and audit, not a higher threshold that resolves the variability by discarding the information.

ANMF alternative

Report both. Retain the existing measure of a decline of 1 point or more and introduce a separate measure of a decline of 2 points or more. This approach:

- preserves the early warning signal that reablement responds to
- isolates the clinically unambiguous decline that the proposal is seeking
- allows the question of measurement variability to be examined empirically by comparing the two series over time
- avoids a discontinuity in the published national series

6.2 A 2 Additional reporting for decline in early loss ADL items

> **ANMF position: Support, with conditions.**

- The hierarchical pattern of functional loss is well established, and the early loss items are those where maintenance remains achievable. Early losses are also the first observable indication that a resident is not receiving sufficient hands-on support.

Conditions and a question on the definition

- Item level reporting of Barthel Index scores, rather than the total alone, is a genuine increase in reporting work and must be system generated.
- ANMF questions the inclusion of stair climbing in the early loss group. Few residents in residential aged care use stairs, and many homes are single level or lift serviced. The item will not discriminate and may not be reliably assessed. ANMF suggests the early loss group be defined as bathing, grooming and dressing, with stair climbing excluded or reported separately.
- ANMF further suggests the Department consider whether toilet use, classified as a mid-loss item, warrants separate reporting. Of all Barthel Index items it is among the most sensitive to the availability of staff, and it relates directly to the continence measures proposed elsewhere in this review.

6.3 A 3 Additional reporting for residents who improve after admission

> **ANMF position: Support.**

- Many residents enter residential aged care directly from an acute hospital stay, deconditioned and at their least independent. With rehabilitation, encouragement and time, a proportion improve. None of that work is presently visible anywhere in the Quality Indicator Program.
- An indicator set that records only deterioration cannot demonstrate what good care achieves and provides no measurable recognition of the reablement work that nursing and care staff undertake.
- ANMF notes one matter for interpretation rather than as a condition: the degree of improvement in the first quarter after admission partly reflects how deconditioned a resident was on arrival. A home admitting resident with higher acuity may record greater improvement. Context will be required before the measure is compared between services.

7. Workforce quality indicator

7.1 W 1 New reporting of the share of direct care hours delivered by agency staff

> **ANMF position: Support, conditional on parallel reporting of hours worked above contracted hours by directly employed staff.**

- ANMF supports closing this gap. Agency staff are effectively excluded from the existing indicator because they rarely meet the 120-hour threshold required to count as employed. A residential aged care home can therefore rely substantially on agency staff and report low turnover. In a measure intended to convey continuity of care, that is a material omission.
- Agency reliance also has direct consequences for our members and creates risk for residents. When care is provided by staff who may be unfamiliar with residents' individual needs, preferences and early signs of deterioration, the risk of missing changes in condition and reducing continuity of care is increased. Permanent care staff carry the additional responsibility of orientating and supervising agency staff on every shift, in addition to their own workload.

On the definition of agency staff, which the review raises as a question

ANMF submits the measure should capture all direct care hours not delivered by staff directly employed by the approved provider, across all four roles currently within the indicator. This should expressly include labour hire, contracted and digital platform arrangements. Limiting the definition to traditional nursing agencies could create opportunities for providers to shift to alternative workforce models undermining its integrity, reducing the value as a workforce indicator

Condition

The measure must be introduced together with reporting of hours worked above contracted hours by directly employed staff.

- A measure that presents agency use as a negative, with no corresponding visibility of the alternative, creates a direct incentive for services to meet staffing shortfalls by pressing permanent employees into additional shifts.
- That response transfers risk onto the existing workforce, in the form of fatigue, extended hours and the associated clinical risk, and it is not visible anywhere in the Quality Indicator Program. ANMF has observed this dynamic in other workforce settings and raises it here before it is created.
- Reporting both figures together gives an accurate picture of how a home fills its roster. Reporting only one creates an incentive to move the shortfall to where it cannot be seen.

Finally, ANMF asks that program guidance frame agency reliance as a symptom of recruitment and retention difficulty rather than as a failing attributable to individual agency nurses, who are frequently the reason a shift is safely covered at all.

7.2 W 2 Replace the existing staff turnover measure

> **ANMF position: Support, with conditions. Should be adopted together with W 1.**

- The existing construction, combining a 120-hour employment threshold with a 60-day absence rule, produces turnover rates that do not align with sector experience. Providers themselves report that results differ significantly from those produced by conventional

methods. A quality indicator that is not regarded as credible by either those who report it or those it describes cannot function as an effective measure for quality improvement.

- A conventional measure will be simpler to calculate correctly, will improve compliance and data quality, and will be comparable with turnover measures used in other sectors.

Conditions

- It must be adopted together with W 1. Excluding agency staff from a turnover measure, without separately reporting agency hours, removes agency churn from the picture entirely and would leave the program with less information about continuity than it has now.
- The former and revised series must be published in parallel for at least four quarters, consistent with section 3.3. A higher figure under the revised method is a measurement change and must be communicated as such, or it will be misread as a deterioration in the sector.

7.3 W 3 Rename the workforce domain to continuity of care

> **ANMF position: Not supported.**

- Workforce is the accurate description of what this domain measures: who is employed, who leaves, and, if W 1 proceeds, who is engaged through agency arrangements. These are inputs.
- Continuity of care is an outcome to which workforce stability contributes, alongside rostering practice, model of care and other factors. Naming a domain for an outcome it does not measure obscures the input that it does measure.
- There is a practical consequence. A domain named continuity of care invites responses directed at rostering and consistent assignment. Those practices have value, but they do not address the underlying question of whether a home has enough appropriately skilled staff. The word workforce keeps that question in view for providers, for consumers and for government.
- ANMF also notes that consumers, residents and families readily understand the term workforce. Aged care is a service delivered by people, and the workforce is what families ask about. Continuity of care is a less concrete concept for a non-clinical audience.

- The problem identified in consultation is that some providers did not understand the intent of the domain. That is properly addressed through guidance material, factsheets and the program manual, rather than by renaming the domain.

If the Department considers a change necessary, ANMF would not oppose the term workforce continuity, which retains the input being measured while making the purpose explicit.

8. Defining a virtual emergency department presentation

The Quality Indicator Program Manual defines an emergency department presentation as occurring when an individual presents to an emergency department or urgent care centre, including presentations occurring in person or via a technology enabled platform such as telehealth or virtual services. However, the term technology enabled platform is not further defined and does not adequately reflect the range of contemporary models of care and treatment pathways that can provide assessment and management without a conventional presentation.

Without a definition it is presently unclear whether the following are reportable:

- telehealth consultations with a general practitioner or after-hours locum service
- a paramedic attending the home and consulting a remote emergency physician
- hospital operated nurse practitioner or geriatric outreach services
- scheduled hospital in the home virtual rounds
- telephone advice sought from an emergency department that does not result in a registered presentation
- virtual nursing or clinical support services contracted directly by the approved provider

ANMF draws particular attention to the final category. If a virtual clinical support service contracted by a provider is reportable as an emergency department presentation, a residential home may substitute a remote service for an on-site registered nurse and have that substitution recorded as appropriate clinical escalation. ANMF does not consider this outcome consistent with the objectives of the program, which should promote access to clinically appropriate care.

ANMF also notes that the reporting incentive created by the indicator changes depending on a policy decision that has not yet been made. While virtual presentations remain within the total indicator, providers have an incentive to under-report, since each recorded contact increases the overall rate. Conversely, if virtual presentations are subsequently excluded from the total, as the review contemplates, the incentive would reverse and a loose definition would permit reclassification. A clear and tightly defined reporting framework is necessary to preserve the intent of the measure regardless of the decision.

Proposed definition

ANMF submits that a presentation delivered by technology enabled platform should be reportable only where all three of the following apply:

- the contact is with a hospital emergency department or urgent care service, and not with a general practitioner, locum, medical deputising service or a provider contracted supplier
- the resident is formally registered by that service as a presentation, generating a record in the hospital's own information system
- the contact results in clinical assessment and a disposition decision, being to treat in place, transfer, or refer

Expressly excluded and reported separately if the Department considers that information useful: general practitioner and locum telehealth, after hours medical deputising, provider contracted virtual nursing or clinical support services, telephone advice not registered as a presentation, and scheduled hospital in the home visits.

ANMF suggests the registration test is the workable element of this definition. It is objective, it is auditable against hospital records, and it does not require a nurse to make a categorisation judgement during a clinical episode, frequently overnight.

9. Additional measures ANMF proposes

The following four measures arose through ANMF consultation and are not among the enhancements proposed by the review. ANMF asks that the Department consider them.

9.1 A single record for each case of incontinence associated dermatitis

Rather than selecting between reporting prevalence and reporting new cases, ANMF proposes that each case of IAD be recorded once, with the date it was identified and the date it was resolved.

A single record of that kind yields, from one entry:

- prevalence in the reporting period
- new cases arising in the reporting period
- cases unresolved and carried forward
- time to resolution, which is itself an indicator of care quality and is not presently captured anywhere

This approach addresses the attribution concerns underlying both I 1 and I 3 while reducing, rather than increasing, the reporting burden on nursing staff.

9.2 A measure of continence regained

The program does not record how many residents admitted with incontinence regain continence following appropriate assessment, toileting support and care. ANMF asks the Department to consider such a measure alongside I 2.

An indicator set that records only loss of function cannot demonstrate what good clinical care underpinned by adequate staffing can achieve. A measure of continence regained would provide that evidence, support the review's emphasis on prevention, and recognise that decline in continence is not always inevitable. It would encourage services to invest in continence assessment and toileting programs rather than treating incontinence as addressed on admission.

9.3 A two-tier measure of functional decline

Set out at section 6.1. ANMF proposes reporting a decline of 1 point or more and, separately, a decline of 2 points or more, rather than replacing the former with the latter.

9.4 Reporting of hours worked above contracted hours by directly employed staff

Set out at section 7.1. ANMF submits this measure is necessary to prevent the agency reporting requirement from creating an incentive to transfer staffing shortfalls onto permanent employees, where they would not be visible. It also provides the program with information on workload intensity that it presently lacks entirely.

10. Conclusion

ANMF supports the direction of this review. Ten of the twelve proposed enhancements improve the program, and ANMF supports them subject to the conditions set out above, principally that data capture is automated, that risk adjustment precedes publication, and that changes to published measures are accompanied by parallel reporting.

ANMF does not support raising the threshold for functional decline, which would reduce reported decline without improving care, and proposes a two-tier measure in its place. ANMF does not support renaming the workforce domain, which would obscure the input the domain measures.

The two most significant enhancements in this review are the reporting of agency hours and the proposed indicator for incontinence developing after admission. Each would, for the first time, provide national evidence on matters that have until now been argued without data. ANMF supports both and has set out in this submission the conditions we consider necessary for each to measure what it is intended to measure.

ANMF would welcome the involvement of nursing representatives in pilot data collection for any enhancement that proceeds, particularly in assessing reporting burden and the practicality of capture through existing care management systems.