

A Consultation: Catheter-associated care and complications in Victorian residential aged care homes

Final Report

Prepared by:

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Contributing Authors/Project Team: Professor Joan Ostaszkiewicz, Associate Professor Frances Batchelor, Dr Andrew Gilbert, Dr Jessica Cecil, Marie Vaughan, Caitlin Tay, Isabella Hall, Professor Briony Dow

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ABBREVIATIONS

ANUM	Associate Nurse Unit Manager
CALD	Culturally and Linguistically Diverse Background
CAUTI	Catheter-Associated Urinary Tract Infection
CDC	Centers for Disease Control and Prevention
CEO	Chief Executive Officer
CNC	Clinical Nurse Consultant
DoH	Department of Health
EN	Enrolled Nurse
GP	General Practitioner
IDC	Indwelling Urinary Catheter
MoU	Memorandum of Understanding
NARI	National Ageing Research Institute
NP	Nurse Practitioner
PCA	Personal Care Assistant
PICF	Participant Information and Consent Form
RACF	Residential Aged Care Facility
RIRS/RIR	Residential-In-Reach Services
RN	Registered Nurse
SPC	Suprapubic Catheter
UTI	Urinary Tract Infection

EXECUTIVE SUMMARY

In 2023, the National Ageing Research Institute (NARI) conducted a consultation with residential aged care stakeholders to provide insights into the experience of caring for aged care residents with indwelling urinary catheters (IDCs), the care they receive, and barriers to receiving care. IDCs are a source of angst for people who require them and for those who care for them, particularly when they are used long-term. They represent a significant clinical risk and are associated with functional decline, increased hospital stays, inappropriate or inadequate antimicrobial treatment, and an overall increase in mortality rate compared with residents without an IDC. Nevertheless, international research indicates 5-8% of aged care residents require a long-term IDC.

In Australia, the day-to-day care of people with IDCs in residential aged care homes typically falls to personal care workers and nurses. In 2022, NARI conducted a review of Victoria's Residential-in-Reach Services. Eighty-three percent of these services reported providing routine catheter changes for residents (i.e. care that should fall within the remit of an aged care provider). In 2023, the Victorian Department of Health commissioned NARI to consult with key stakeholders to explore the nature of the issues in more depth, including the extent to which the residential aged care workforce feels equipped with the knowledge, skills and confidence to deliver IDC care.

In the current consultation, we conducted an online survey of residential aged care managers (n=28), interviewed 10 residential aged care staff working in clinical roles, conducted two focus groups with 21 employees in clinical or consulting roles from Residential-in-Reach Services in Victoria, and interviewed one resident with an IDC. The survey completed by managers indicated 6% of 2,068 residents (n=122) had an IDC at the time of the survey. Managers reported being equipped to respond to the care needs of aged care residents with IDC, i.e. that although residents with catheters commonly experienced IDC-related complications, these complications were managed in-house.

However, this finding was not consistent with qualitative findings from focus groups with Residential-in-Reach employees or interviews with residential aged care staff. They described challenges to best practice IDC care centred on the lack of internal expertise to change catheters and to respond to complications. They stated that this was mainly due to a deskilled residential aged care workforce. Whilst Residential-in-Reach Services provide invaluable support to residential aged care homes and are highly skilled in caring for people with catheters, they report an overreliance on them for expertise related to catheter care that they believed should be available to residents with catheters within the home.

The gaps identified in this consultation suggest many RNs working in the aged care sector do not feel confident to perform urinary catheterisation, change a suprapubic catheter, nor assess and manage the issues that commonly occur with long-term catheterisation. Undergraduate nursing programs in Australia provide nurses with the knowledge and skills required to undertake the procedure of inserting and removing a urethral urinary catheter. Therefore, the insertion and removal of a urethral catheter is within the scope of practice of a Registered Nurse (RN). However, the focus of education programs and clinical experience is on short-term

catheter management. In nursing undergraduate education and in acute care settings, nurses have limited contact with people with long-term catheters. Their exposure to the clinical complications associated with long-term urinary catheterisation is likely to also be limited. Hence, most nurses are unlikely to be educationally prepared to prevent and manage the risks associated with long-term urinary catheterisation. To ensure they are able to meet the needs of residents with an IDC, nurses working in aged care should undertake further professional development on this topic and thereby expand their scope of practice. Unlike urethral catheterisation, the initial insertion of a suprapubic catheter is a medical procedure and is usually undertaken in a day surgical setting, with the first catheter change being undertaken by an experienced medical practitioner or a specialist advanced practice nurse. The subsequent replacement of a suprapubic catheter should only be performed by a healthcare professional with requisite knowledge and skill. The extent to which nursing education programs in Australia equip nurses with the knowledge and skills to preform suprapubic catheter changes warrants further investigation, as does the need for education pathways designed to address this workforce gap. It should also be noted that RNs are required to maintain their capability to practice as regulated health professionals consistent with the Nursing and Midwifery Board of Australia (NMBA) Registered Nurse Standards for Practice. The standards state RNs are responsible and accountable for ensuring they are safe and have the capability for practice. They are accountable for the management of people in their care. Therefore, if they do not have the knowledge and skills to meet the health needs of the people they serve, they have a responsibility to develop their scope of practice and capabilities.

There may be multiple reasons for RNs' apparent lack of capability to deliver IDC care in residential aged care homes. Indeed, some clinical staff and Residential-in-Reach employees claimed undergraduate programs were unlikely to adequately equip RNs with the requisite knowledge and skills. Reductions in patients' length of stay in hospitals has also reduced opportunities for nursing students to gain experience in caring for patients with IDCs. Moreover, most of the experience they gain relates to short term IDC care and hence, is unlikely to prepare them for the complications associated with long-term catheterisation. A lack of clinical mentorship and a lack of guidelines were also cited. The apparent deskilling could also relate to local policies and procedures that discourage RNs from managing the complications of long-term catheterisation within the aged care setting.

Some interview respondents stated the lack of skills to provide holistic care to residents with IDCs impacted on residents' access to timely interventions and increased their risk of death. For example, delays in responding to symptomatic catheter-associated urinary tract infection and blockage can have devastating effects on morbidity and mortality. The presence of an IDC is also likely to impact on a person's psychological wellbeing. Staff's focus on the technical challenges associated with the need for residents to have their catheters regularly replaced and to respond to IDC-related complications suggests limited awareness of the personal impacts for residents themselves and/or their information and support needs and those of their families. Based on this consultation, we recommend improved training and education for residential aged care staff, not only on the technical aspects of caring for residents with IDC, but also to equip them with the knowledge, skills and confidence to psychologically support residents with an IDC to live well. Indeed, interview respondents identified the need for improved communication processes about catheter care, education and upskilling for staff, increased RN and managerial leadership, and IDC guidelines and resources.

1. BACKGROUND

International estimates indicate 5-8% of people in residential aged care facilities (RACF) have an indwelling catheter (IDC) to manage a bladder condition (1-3). Although IDCs are potentially beneficial, they are associated with significant morbidity and mortality (4). The most significant and prevalent complication reported in the literature is catheter-associated urinary tract infection (CAUTI), which increases with the duration of IDC use. To this end, the US Centers for Disease Control and Prevention (CDC) (4) recommend the following:

- IDCs should only be inserted for appropriate indications and left in place only as long as needed.
- IDC use and duration of use should be minimised in all patients, particularly those at higher risk for CAUTI or mortality from catheterisation such as women, older people, and patients with impaired immunity.
- IDCs should be avoided in patients and nursing home residents for management of incontinence.
- IDCs should only be used as necessary in patients undergoing surgery, rather than routinely.

Indications for IDC use

Indwelling catheter use should be limited to people with medically prescribed conditions and only where there is no other alternative form of management available. The CDC (4) provide examples of appropriate IDC use (Box 1).

BOX 1.

- Patient has acute urinary retention or bladder outlet obstruction.
- Need for accurate measurements of urinary output in critically ill patients.
- Perioperative use for selected surgical procedures:
 - Patients undergoing urologic surgery or other surgery on contiguous structures of the genitourinary tract.
 - Anticipated prolonged duration of surgery
 - Patients anticipated to receive large-volume infusions or diuretics during surgery.
 - Need for intraoperative monitoring of urinary output.
- To assist in healing of open sacral or perineal wounds in incontinent patients.
- Patient requires prolonged immobilisation (e.g. potentially unstable thoracic or lumbar spine, multiple traumatic injuries such as pelvic fractures).
- To improve comfort for end-of-life care if needed.

Most people with IDCs in RACF have a long-term IDC. To reduce the risk of catheter related problems such as encrustation and blockage, long-term IDCs need to be replaced on a regular, but individualised basis, consistent with the functionality of the catheter and the manufacturer's instructions (i.e. no more than 12 weeks) (5). The insertion and replacement of an IDC needs to be medically authorised. There are multiple factors that need to be considered when determining the appropriateness of an IDC, including indications and contraindications. The

assessment of a person's need for an IDC or for replacement of an IDC should involve the varying competencies of the multidisciplinary team, including the GP/medical practitioner and the nurse.

Long-term IDC use

The British Association of Urological Surgeons and Nurses provides the best available evidence about caring for people with long-term IDCs. They define long-term IDC use as one month or longer (i.e., 28 days or four weeks) (5). They recommend:

- (i) Considering alternatives to long-term catheterisation, such as intermittent self-catheterisation for people unable to empty their bladder, and pads or external collection devices when incontinence cannot be treated.
- (ii) Reviewing the person's clinical need for the catheter regularly, and if possible, removing the catheter as soon as possible.
- (iii) Documenting the need for catheterisation, as well as details about insertion, changes and care.
- (iv) Replacing the catheter on an individualised basis consistent with the functionality of the catheter and the manufacturer's instructions (i.e. no more than 12 weeks) in an effort to pre-empt problems such as encrustation and blockage.
- (v) Ensuring consent and addressing the person's information and support needs.
- (vi) Using indwelling suprapubic catheters (SPC) as an alternative to long-term urethral catheters.
- (vii) Avoiding the routine prophylactic use of antibiotics when changing a catheter or when the person has asymptomatic CAUTI - may be appropriate for people with a history of symptomatic UTI after catheter change or who experience trauma during catheterisation.
- (viii) Treating symptomatic CAUTI and changing the catheter following the establishment of antibiotic therapy.
- (ix) Minimising all possible causes of encrustation and blockage of the catheter.
- (x) Avoiding all possible causes of urethral trauma, i.e. avoiding large size balloons, and ensuring catheters are appropriately secured/anchored.
- (xi) Regular urological reviews for people with IDCs with visible haematuria, recurrent CAUTI or new unexplained bladder symptoms.

None of the available guidelines specially address the management of IDCs in RACF.

The risks associated with IDCs in RACF

The risks for aged care residents with IDCs are significant. Catheterisation and resulting bacteriuria are associated with numerous adverse outcomes, such as functional decline, increased hospital stays, inappropriate or inadequate antimicrobial treatment, and an overall increase in mortality rate compared with residents without an IDC (6). Because IDCs are a reservoir for bacteria, people with a long-term IDC commonly develop bacteriuria and subsequent encrustation that can cause catheters to block and leak, resulting in associated damage to the upper urinary tract (7). A survey of 54 people with an IDC in the community in the United Kingdom revealed 48%

reported catheter blockage, 37% reported urine by-passing the catheter and 30% noted visible haematuria over a 6-month period (8). Another risk is the potential for physical trauma to the urethra due to poor technique of catheter insertion or removal (9) or from inadequate support for the urinary drainage bag (10).

Victoria's state-based Residential-in-Reach Services (RIRS) identified IDC care for aged care residents as a significant issue of concern. A recent analysis of their data conducted by NARI and an evaluation conducted by the Australian Centre for Evidence-Based Aged Care (ACEBAC) revealed a high demand for expertise from the service for IDC-related problems. Specifically:

- 100% of RIRS responded to requests to troubleshoot problems related to IDCs in RACF
- 83.3% performed urethral IDC changes
- 79.2% performed SPC changes
- 91.7% performed trial of voids (unpublished)

Although the care of people with an IDC falls within the remit and educational scope of professional practices of Registered Nurses (RN), several studies point to gaps in nurses' knowledge, confidence and decision-making related to IDC use, in terms of:

- Inserting a catheter
- Managing catheter-associated complications
- Understanding the clinical indication for the catheter
- Educating others about catheter care
- Preventing urethral damage
- Removing the catheter when it is no longer required (11-15).

Our analysis of the literature identifies gaps in existing guidelines about IDC care in so far as they tend to focus on short-term management in acute care settings. This emphasis on short-term use fails to address questions about long-term management. In effect, guidelines lack guidance in the context of long-term IDC use and in a long-term aged care setting.

Psychological support/impact

To the best of our knowledge, there is only one study in Australia focused on the lived experience of having an IDC. This mixed methods study conducted with community-dwelling older people with an indwelling SPC identified the following six elements for best practice SPC care (16):

- (i) Psychological support needs
- (ii) Cystostomy site care
- (iii) Catheter replacement
- (iv) Drainage equipment practices
- (v) Complication avoidance and management
- (vi) Planning ahead.

Whilst this is an important study, the focus was on self-management, so the transferability of the findings to IDC-care in RACF is unclear.

What we don't know

Although the RIRS reports problems with IDC care of residents in Victorian RACF that increases the demand for their services, there is a lack of information about the specific types of IDC-related complications, how complications are currently managed, and residents', families' and staff members' experiences of, and satisfaction with, IDC care. This information is important if we are to enhance understandings of workforce knowledge and skills about IDC care, referral pathways to IDC care provided by specialist services, General Practitioner (GP) involvement, service capacity, and funding or policy, with the aim of improvement in each of these domains. Given the gaps in knowledge and the significant clinical risks associated with the use of IDCs, particularly for long-term management, we consulted key stakeholders to obtain an in-depth understanding of IDC-related care in RACF.

2. OVERVIEW

2.1 Purpose

NARI conducted this consultation in response to a need identified by Victoria's state based RIRS to improve the quality of care for aged care residents with an IDC.

2.2. Study Aim

Our aim was to obtain insights into the experience of living with an IDC in RACF, caring for a resident with an IDC, and the barriers to care.

3. METHODOLOGY

3.1 Design

The consultation used a mixed methods approach. Quantitative data were obtained through a survey, and qualitative data were collected from individual interviews and focus groups.

3.2 Participants and Recruitment

3.2.1 Participants

The following four key stakeholder groups were invited to be part of the consultation:

- (i) RACF residents with an IDC in a Victorian RACF
- (ii) RACF managers
- (iii) RACF staff working in clinical roles
- (iv) RIRS employees working in clinical and consulting roles

Exclusion criteria

Participants were excluded from participating in the interviews or focus group if they did not have the capacity to provide their own consent. The online survey for managers and recruitment materials were in English language and interpreters were available.

3.2.2 Recruitment Methods

NARI promoted the project to RACF and organisations with which it has a formal memorandum of understanding and/or working relationship in Victoria, and to Victorian aged care advocacy groups. Recruitment information was also placed on NARI's website. There were three recruitment phases. In the first stage 190 emails were sent to CEOs and RACF managers. Due to a poor response rate, the second recruitment effort involved sending 215 emails (75 emails to higher level management (CEOs/managers) and 140 to RACF administrative email addresses. The third recruitment phase involved 280 direct calls to RACF. A follow up email was then sent to each RACF. This stage of the recruitment required an ethics amendment.

Focus group with Residential-in-Reach Service employees

The first part of the consultation involved seeking the opinions and experiences of employees of Victoria's RIRS. They were informed about the opportunity to participate in a focus group from an information session provided to them at one of their networking meetings. We aimed to recruit twelve employees of Victoria's RIRS to participate in the focus groups. To ensure representation across the sample, participants were sampled from metropolitan, regional and sub-regional services. Participation was voluntary. See Table 1 for the recruitment target by location.

Table 1. Recruitment target by location for Residential-in-Reach Service employees

Health Services	Metropolitan	Regional	Sub-regional
Number (percentage)	10 (40%)	5 (20%)	10 (40%)
Focus group recruitment target	4-6	2-4	4-6

Survey of RACF managers

Using a stratified sampling strategy, an invitation was sent to the managers of a representative sample of Victorian RACFs together with the link to an anonymous online survey. RACFs were sampled for size (small, medium, large), organisation type (not-for-profit, government-run, private) and location (metropolitan, regional). We aimed to recruit 114 managers from Victorian RACF to complete the survey. See Table 2 for the recruitment target by size, organisational type and location.

Table 2. Recruitment target by size, organisational type and location for RACF managers

Organisational type	Not-for-profit	Government	Private
Number (percentage)	280 (36.9%)	158 (20.8%)	320 (42.2%)
Recruitment target	42	24	48
RACF Location	Metropolitan	Regional	Rural
Number (percentage)	63%	21%	16%
Recruitment target	72	24	18
RACF Size	Small (<40 residents)	Medium (40-100 residents)	Large (>100 residents)
Number (percentage)	18%	33%	49%
Recruitment target	21	38	55

Interviews with RACF residents and clinical staff

RACF managers who received information about the opportunity to complete the survey were also invited to promote the consultation to clinical staff and residents in their RACF. We aimed to recruit ten residents and ten clinical staff. To ensure representation within the sample, we sampled for diversity, inclusive of participants from culturally and linguistically diverse (CALD) backgrounds and different RACF types, i.e. private, public sector and not-for-profit, rural, regional and metropolitan areas of Victoria.

3.3 Data Collection

Focus group with Residential-in-Reach Service employees

Residential-in-Reach Service employees were invited to review and provide feedback on the proposal strategy to conduct the consultation with RACF managers, clinical staff and residents. This included the recruitment materials, and the survey and interview questions and prompts. They were then invited to share their experiences of providing support to RACF about:

- IDC care
- Their perceptions of challenges for RACF residents and staff
- Staff roles, responsibilities and capabilities related to IDC care
- The structures and processes they believed were required to minimise and manage IDC-related complications.

Online Survey of RACF managers

Managers were invited to complete the anonymous online survey about:

- The number of residents with an IDC

- The proportion who experienced problems
- The nature of the problems
- The number of referrals to the RIRS for IDC-related complications
- The number of admissions to emergency departments for IDC-related complications
- The reasons for IDC use, resources and supporting services available to them
- Their confidence about staff capabilities to care for residents with IDCs.

Interviews with RACF clinical staff

RACF staff working in clinical roles were invited to discuss:

- The challenges they experienced in caring for residents with an IDC
- Their perceptions of the roles and responsibilities of different staff members in caring for residents with an IDC
- Staff capabilities to prevent and manage complications
- Structures and processes to minimise and manage IDC-related complications
- The effectiveness of these structures and processes
- Strategies to improve IDC care in Victorian RACF
- The resources and supports available to them
- Their confidence in caring for residents with an IDC.

Interviews with residents with IDCs

The interview for residents was designed to elicit information about:

- Their experience of having an IDC
- The impact on their life
- The challenges they may or may not have experienced with their IDC
- The strategies they employ/employed to minimise and manage complications
- How IDC-related complications are/were managed
- Their satisfaction with the care they receive/received to minimise and manage these complications.

Interviews were between 30 to 60 minutes in duration. Residents were offered the opportunity to be interviewed in person (face-to-face) on-site or by phone – depending on the person's preferences, availability, and COVID-19 restrictions. An interpreting service was offered to people with limited or no English language proficiency. Interviews were audio recorded with participant consent.

3.5 Ethics

The project was approved by Bellberry Human Research Ethics Committee on 3rd May 2023 HREC Reference Number: 2023-01-027 ([Appendix 20. Bellberry Ethics Approval](#)). All interview and focus group participants were sent information about the study and provided written consent prior to data collection. Participants' consent was also verbally confirmed during interviews/focus groups. Any identifying information about participants or their RACF or employment was removed to protect confidentiality. All documents are contained in [appendices 1– 19](#).

3.4 Data Analysis

RACF Manager Survey: The quantitative data collected were described using means and standard deviations for normally distributed continuous data, and numbers and percentages for categorical data.

Residential-in-Reach Focus Groups and RACF Interviews: Focus groups and interviews were professionally transcribed, and independently read through by two researchers for familiarisation. Preliminary notes were recorded by both researchers and informed a thematic analysis. The approach to the thematic analysis was informed by methods proposed by Braun and Clarke (17, 18). After the key themes were identified and defined, author 1 reviewed the background literature search to compare and contrast the thematic findings with existing research on the topic.

4. KEY FINDINGS

4.1 Residential-in-Reach Service Focus Groups

4.1.1 Demographic characteristics

The two focus groups were convened with RIRS employees who were a part of a RIR Community of Practice. A total of 21 employees attended the focus groups and were from metropolitan, regional and remote areas of Victoria.

4.1.2 Findings

Main reasons for referrals related to IDCs

Residential-in-Reach employees identified two referral types for IDC care. The first was to perform regular routine changes of catheters on residents who had no complications. They felt this activity should be undertaken on site within the RACF by RNs and that it should be part of an RN's scope of practice. The second referral type was for support to troubleshoot IDC-related problems, such as bypassing, blockage, traumatic catheter removal, infection and to perform trial of voids. Most referrals were from the RACF, but others were from urology clinical nurse consultants (CNC), urology units, hospitals, and GPs.

Perceived challenges for aged care residents with an IDC

Residential-in-Reach employees felt living with an IDC would be an uncomfortable and confusing experience for residents, particularly for those with significant cognitive impairment. They stated some residents expressed a lack of confidence in the RACF staff but showed confidence in RIRS' clinical knowledge and skills.

Residents who are cognitively intact don't often have lots of confidence in the residential aged care staff. I had one last week, he said, "They don't know what they're doing, they're asking me where to put the tubes," so he didn't want anybody to touch it at the RACF.

(Participant 1)

Much of our resident or patient group have cognition issues...so it's probably just a very disorientating, uncomfortable experience, because they don't understand. (Participant 2)

Perceived gender differences in aged care residents' experiences of having an IDC

Prompts about potential gender differences in aged care residents' experiences of having an IDC elicited information from RIRS employees about inconsistent policies and practices for the insertion of catheters, which were based on residents' gender. Specifically, some RIRS employees stated some RACF had policies that hindered staff from inserting or removing a catheter for males even when individual RNs were competent to perform catheterisation and when the resident had no known complications.

We do a lot of routine changes, mainly SPCs and male IDCs...quite often the facility is saying that the staff are not allowed to do it. (Participant 3)

Perceived challenges for RACF staff when caring for residents with an IDC

Residential-in-Reach employees stated that RACF staff had a lack of opportunity, experience and confidence in changing catheters, particularly for male residents and for residents with SPCs.

If the RNs are not changing catheters, then I would argue that they cannot care for the catheter because they don't understand the mechanics. (Participant 4)

One of the staff who we are educating with the routine changes hadn't even changed a catheter in her undergrad. So you can't expect them to do it when they've got no experience. (Participant 3)

According to one RIRS employee, RACF staff are limited by under resourcing in the RACF environment. They described RACF as environments characterised by a lack of adequately trained and clinically skilled nurses and an overreliance on agency staff, which complicated the situation and influenced the RIRS employees' decisions to intervene.

I think it's a time management issue too. Some of our facilities are actually operating entirely off agency staff - every single nurse on the floor - and they're actually expressing that they are feeling out of their depth. (Participant 2)

Another perceived challenge was that some GPs insisted that catheters be changed every six to eight weeks,

regardless of how they were functioning.

It's [routine catheter changes] such a waste of money, such a waste of everybody's precious time. (Participant 1)

Understanding of the roles and responsibilities of different RACF staff members in caring for residents with an IDC

Residential-in-Reach employees believed RNs working in RACF should be competent in safe catheter management. They indicated this competence consisted of knowing how to insert and remove uncomplicated catheters, ensure appropriate fastening, free drainage of the urine, changing drainage bags, identifying anomalies such as blockage, bypassing, pain, haematuria, urethral or stomal trauma, encrustation and CAUTI, and educating Personal Care Assistants (PCAs) on the day-to-day care of residents with catheters. To address gaps in PCA knowledge about catheter care, a RIRS employee described delivering this education herself.

I have performed education with PCAs in a facility because they didn't even understand how the catheter worked, how it was held in, why it was important for gravity drainage... a little half hour education session with them to understand the plumbing of the catheter, that's half the battle. And it gave them a great deal of insight. Not to touch the catheter, as in not in a clinical sense, but just for the external management of emptying and understanding why it's important not to kink it and things like that. (Participant 3)

Perceived capabilities of RIRS and RACF staff to prevent and manage complications associated with IDCs in Victorian RACF

Residential-in-Reach employees questioned the confidence and competency of the RACF workforce to care for residents with an IDC and were uncertain about what was and was not in RNs scope of practice. Given this, there was a range of opinions about how RIRS should respond to requests for support with IDC care. Some RIRS employees considered it reasonable to accept referrals for male residents with an IDC, but stated female residents with an IDC should be managed within the RACF. There was a perception among RIRS employees that inserting a catheter into a female resident was within the scope of practice of every RN, whereas the insertion of a catheter into a male resident was more complex and required additional skills. For example, a RIRS employee said:

We do not attend to any female urethral, simply because it's deemed to be within the scope of practice of an RN Div 1... We do get asked, on a fairly regular basis. If they're having a particular issue, or if they're short-staffed, or the classification of nursing staff that are attending does not have the capacity to change the catheter - if it is in the best interest

of the resident and the hospital to circumvent that presentation, we will look at things on an individual basis. (Participant 2)

Other RIRS employees agreed that IDC care should be in the RACF RNs' scope of practice, but accepted referrals for both male and female residents with an IDC. Others believed the insertion of a urethral catheter was within RNs scope of practice, but insertion of a SPC was not.

Most RIRS employees expressed the view that RNs in RACF were 'deskilled' and had not maintained clinical competence. They felt that this deskilling was perpetuated by RIRS filling the gap. One RIRS employee stated this was a "vicious cycle" and suggested that RACF RNs should be more willing to take responsibility for management of catheter care rather than outsourcing to hospital services.

And that's a vicious cycle: because we do it for them, then they don't want to learn to do that for themselves. (Participant 4)

Structures and processes required to minimise and manage complications associated with IDCs in Victorian RACF

Residential-in-Reach employees identified the need for more education for RACF staff, including PCAs about IDC care. Whilst some RIRS employees described mentoring RACF staff to troubleshoot IDC-related problems when they responded to requests for support, others described collating and disseminating information about education programs for RACF staff on IDC care.

We are encouraging all the facility nurses to undergo a course. We've got - on our board - who are running the courses, how much it costs, what the dates are, and we forward that to the staff at the facilities. (Participant 1)

Other strategies required to improve catheter care in Victorian RACF

Residential-in-Reach employee suggestions for improving IDC care in Victorian RACF centred on the need for RACF nurses to receive education about IDC care. One person suggested this education should be mandatory. They identified the need for ongoing assessment of nurses' clinical competence to insert and change a catheter. One RIR employee suggested that urology departments could offer education and clinical competency in how to perform catheterisation to RNs and ENs.

I had that idea that maybe a urology department would allow our nurses to come in and be shown how to do a catheter. I don't know if we can make that a collaboration, because I think that's the issue; they need to sort of continue doing it and skill up. (Participant 4)

Another strategy that RIR employees thought might improve catheter care was having a catheter care champion on site in each RACF.

There should be a champion at each facility. Maybe that's something that we should be advocating for (Participant 5)

Access to specialists

Access to specialists to address complex IDC-related problems was also important according to some RIRS employees.

If we're having frequent blockages or frequent haematuria or anything like that, that's when we will put in a referral to urology, or we've got clinical nurse consultants that we liaise with. (Participant 2)

Catheter supplies

Residential-in-Reach employees described instituting policies to minimise call-outs to RACF that did not have the necessary catheters. According to one employee, each RACF should have a standard supply of catheter equipment.

It needs to be a standardised thing through all facilities, that they have this particular supply, these particular sizes [of catheters]. (Participant 4)

In other cases, RIRS employees stated they would supply equipment if the case was urgent.

We supply all equipment for any 'urgents' [residents with urgent catheter related problems], but for routines [residents requiring a routine uncomplicated catheter change] we ask the facility to provide the necessary equipment. (Participant 2)

To minimise burden on the RIRS, the employee stated she instituted a policy of providing RACF with information about the specific IDC-related equipment in anticipation of the next call out. She said:

Also, each visit we supply a form that says essentially, what needs to be provided on the next visit, that they're to call us one week prior, what the exact catheter size is. We will say to the facility, "We will attend when you have actually provided all of this." So sometimes, unfortunately, that has to force them into actually getting things ready, and it might take a few days, but that's what we do. (Participant 2)

4.2 RACF Manager Survey

4.2.1 Demographics characteristics

A total of 28 survey responses were received and analysed. Of these, 61% (n=17) of responses were from Facility managers, 25% (n=7) were from clinical practice managers/clinical care coordinators, 11% (n=3) were from Senior nurses/Unit managers, and in one response, the clinical position/managerial level was unknown. No regional managers completed the survey. Most respondents were located in Metropolitan Victoria (61% [n=17]), followed by Regional (29% [n=8]) and Rural (7% [n=2]). Fifty-four percent (n=15) were from not-for-profit providers, 28% (n=8) were from private providers, and 18% (n=5) were from public sector RACF. The majority of RACF were medium sized (61% [n=17]), 14% (n=4) were small sized, and 25% (n=7) were large sized.

Table 3. Survey respondents' demographic characteristics (N = 28)

Demographic characteristics	Frequency (%)
Role	
Regional manager (responsible for more than one RACF)	0 (0%)
Facility manager	17 (61%)
Clinical practice manager/clinical care coordinator	7 (25%)
Senior nurse/Unit manager	3 (11%)
Non-management	0 (0%)
Other management / senior clinical position	1 (3%)
Location	
Metropolitan	17 (61%)
Regional	8 (29%)
Rural	2 (7%)
Home Size	
Small (<40 residents)	4 (14%)
Medium (40 – 100 residents)	17 (61%)
Large (>100 residents)	7 (25%)
RACF Structure	
Not-for-profit provider	15 (54%)
Private provider	8 (28%)
Public sector residential aged care service	5 (18%)
TOTAL	28

4.2.2 Findings

Prevalence of IDCs

Respondents to the survey for managers (n=28) reported a total of 2,068 residents living in RACF at the time of the survey. Of the 2,068 residents, 6% (n=122) had an IDC.

Types of IDCs

Of the 122 residents with an IDC, respondents reported that 75% (n=92) had a urethral catheter and 25% (n=30) had a SPC.

Gender differences in IDC use

Of the 92 residents with a urethral catheter, 62% (n=57) were identified as male and 38% (n=35) were female. Of the 30 residents with a SPC, 67% (n=20) were reported as male and 33% (n=10) were female.

Documentation about the reason for the IDC

Eighty-six percent (n=24) of managers indicated residents with an IDC had a documented reason for the IDC, 7% (n=2) stated 'no', and 7% (n=2) were 'unsure'.

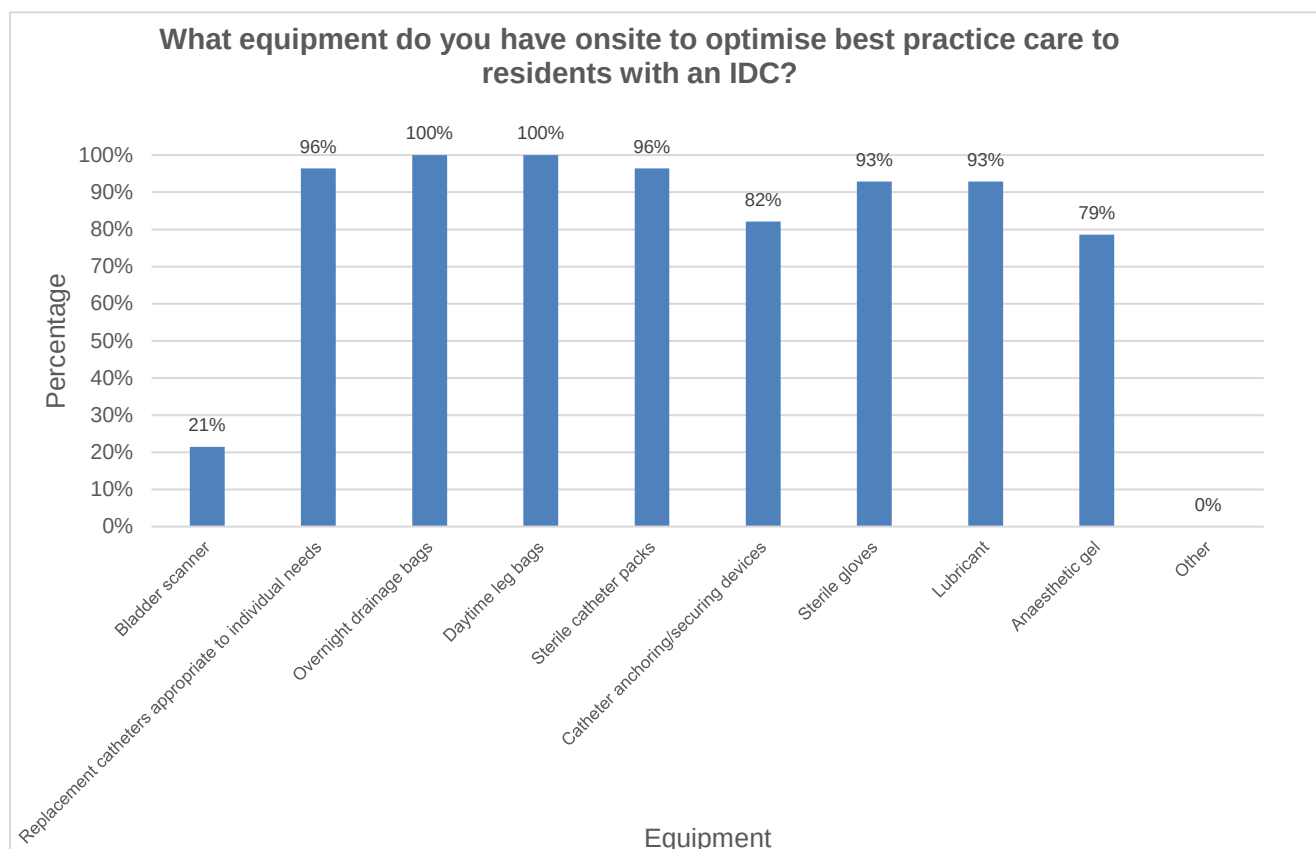
Policies regarding IDCs

Managers were asked to indicate if their organisation had a policy or protocol that allowed RNs/Es to catheterise (i) female residents and (ii) male residents. Most [89% [n=25]] indicated that their RACF had a policy or protocol that allowed RNs/ENS to catheterise female residents, 4% (n=1) said 'no' and 7% (n=2) responded that they did not know. Sixty-one percent of respondents (n=17) stated their RACF had a policy or protocol that allowed RNs/ENS to catheterise male residents, and 35% [n=10]) said 'no'. Data were missing from one manager. The survey did not differentiate between policies related to the insertion of a suprapubic or urethral catheter. Managers were also asked to indicate if they had a policy or protocol that about the need to review the appropriateness of the IDC. Sixty-eight percent (n=19) said 'yes', 25% (n=7) said 'no' and 7% (n=2) indicated they did not know.

Onsite IDC Equipment

Managers were asked to indicate which IDC-related equipment they had available to them for residents with IDCs and were able to nominate more than one option. All respondents indicated they had access to overnight drainage bags, and daytime leg bags, and 96% (n=27) indicated they had replacement catheters onsite that were appropriate to residents' individual needs as well as access to sterile catheter packs. Other IDC-related equipment they reported having onsite included sterile gloves (93% [n=26]), lubricant (93% [n=26]), catheter anchoring/securing devices (82% [n=23]), and anaesthetic gel (79% [n=22]). Twenty-one percent (n=6) indicated they had a bladder scanner onsite (See Figure 1).

Figure 1. Onsite IDC equipment available for IDC residents living in RACF



Health professionals undertaking catheterisations for residents in RACF

The majority of respondents indicated that RNs employed by their RACF (93% [n=26]) and RIRS employees (82% [n=23]) performed catheterisations for residents living with an IDC in their RACF. This was followed by GPs (68% [n=19]) and visiting hospital staff (43% [n=12]).

Catheterisation was reportedly less commonly performed by ENs (25% [n=7]), urology outpatient department (29% [n=8]), emergency department (25% [n=7]), and private urologists (14% [n=4]). One respondent stated that NPs performed their catheter changes and no contracted services performed catheterisations amongst residents in their RACF. Responses do not add up to 100% as respondents were able to nominate more than one option.

The frequency of IDC-related complications (figure 2)

Infection due to the catheter

Fifty-four percent of managers (n=15) reported that residents with IDCs experienced infection due to the catheter 'less than once a month' on average. Twenty-nine percent indicated infection occurred on average in residents with IDCs once or twice a month'. Fourteen percent indicated infection 'never occurred' in residents with an IDC in their RACF.

IDC-related blockage

Managers indicated that blockage of the catheter was a common experience, i.e. 4% of managers reported IDC-related blockage occurred on average several times a week for residents with catheters, 7% (n=2) of managers indicated that residents with a catheter experienced this 'once or twice a week on average' and 21% (n=6) indicated that this occurred on average 'once or twice a month'.

Leakage around the catheter

Leakage around the catheter (hereafter termed 'bypassing') was also frequent according to managers. Seven percent (n=2) of managers stated that residents with a catheter in their RACF experienced bypassing 'once or twice a week' and 39% (n=11) stated that this occurred 'once or twice a month' on average.

Unplanned / traumatic catheter removal

Four percent of respondents indicated that residents with catheters in their RACF experienced unplanned/traumatic catheter removals once or twice a month on average, 29% (n=8) indicated this occurred 'less than once a month', and 64% (n=18) stated that unplanned/traumatic removal 'never occurred'.

IDC-associated pain

Seven percent of respondents (n=2) indicated residents with catheters in their RACF experienced IDC-associated pain once or twice a week on average, 4% (n=1) reported this happened once or twice a month, 46% (n=12) indicated this occurred less than once a month, and 39% (n=11) responded that this 'never occurred'.

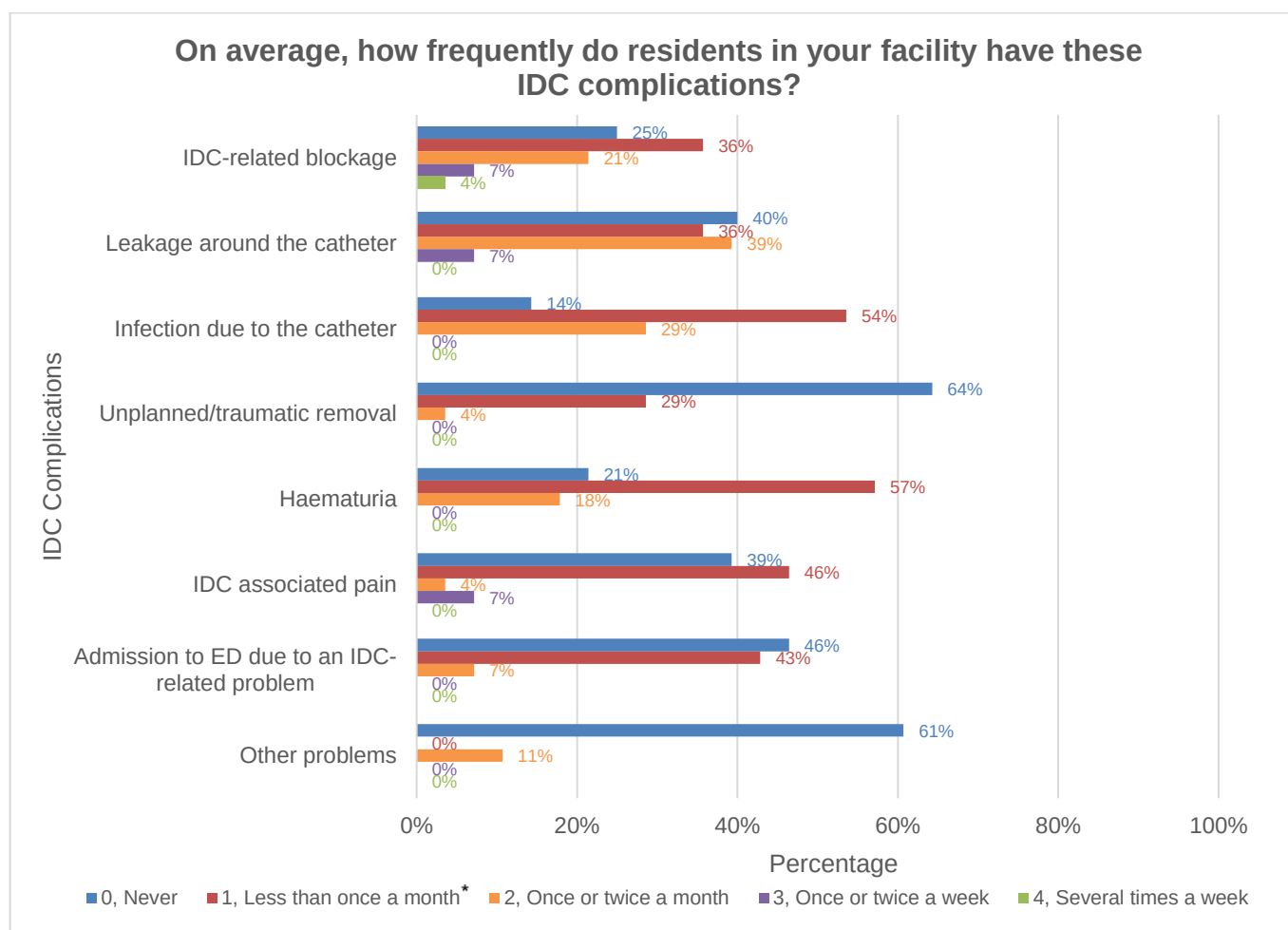
Admission to ED due to an IDC-related problem

Most respondents (46% [n=12]) indicated that residents with catheters in their RACF were never admitted to ED for IDC-related problems, (43% [n=12]) indicated this occurred 'less than once a month' on average and 7% (n=2) reported this happened on average 'once or twice a month'.

Haematuria

Most respondents (57% [n=16]) indicated that residents with IDCs experienced haematuria on average 'less than once a month', 18% reported this occurred 'once or twice a month' on average, and 21% indicated it 'never occurred'.

Figure 2. Reported percentage of IDC complications in RACF residents



*less than once a month = once every 2-12 months

Resolution of IDC-related complications

Most respondents indicated that IDC complications such as IDC blockage, bypassing, infection and haematuria were resolved internally by RACF staff 'most of the time'.

- IDC blockage (61% [n=17])
- Bypassing (50% [n=14])
- Infection due to the catheter (43% [n=12])
- Haematuria (50% [n=14])

Most respondents also identified that referrals to an external service for IDC-related pain 'rarely' occurred (29% [n=8]). Unplanned removals of IDCs were reportedly never resolved by RACF staff (18% [n=5])(Table 4).

Table 4. Frequency (%) of IDC resident complications reported as being resolved by staff type (N = 28)

	Always (%)	Most of the time (%)	Sometimes (%)	Rarely (%)	Never (%)
<i>How often is IDC blockage resolved internally by your staff?</i>	5 (18%)	17 (61%)	2 (7%)	2 (7%)	1 (4%)
<i>How often is bypassing around the catheter resolved internally by your staff?</i>	6 (21%)	14 (50%)	6 (21%)	0 (0%)	1 (4%)
<i>How often is infection due to the catheter resolved by the resident's GP or GP locum service alone?</i>	9 (32%)	12 (43%)	2 (7%)	1 (4%)	2 (7%)
<i>How often are unplanned removals of IDCs resolved internally by your staff?</i>	5 (18%)	10 (36%)	3 (11%)	3 (11%)	5 (18%)
<i>How often is haematuria in residents with IDCs resolved without referral to external services?</i>	1 (4%)	14 (50%)	9 (32%)	1 (4%)	2 (7%)
<i>How often is IDC-related pain referred to an external service?</i>	6 (21%)	3 (11%)	7 (25%)	8 (29%)	2 (7%)

Please note that 'N' does not always equal to 28 in each row due to missing response/s

Referrals to Victorian RIRS

The majority of RACF managers reported referring to RIRS between one to six times in the last 3 months for residents with IDCs. Of these referrals, respondents stated that none were resolved over the phone and one to five required an on-site visit/consultation from the RIRS.

Staff knowledge and skills to care for residents with IDCs

RIRS Respondents were asked to indicate if they agreed the statement: "I am confident that staff in my home have the knowledge, skills and capacity to care for residents with IDCs". The majority of respondents strongly agreed (38% [n=11]) or agreed (32% [n=9]) with this statement, whereas 21% (n=6) were neutral, no respondents disagreed, and 7% (n=2) strongly disagreed.

4.3 RACF Interviews with Clinical Staff

4.3.1 Demographics characteristics

A total of ten interviews were conducted with clinical staff employed in a Victorian RACF. Of these, 60% (n=6) were from metropolitan Melbourne, while 40% (n=4) resided in regional or rural areas. None of the participants identified as Aboriginal and/or Torres Strait Islander. The majority of participants (60% [n=6]) indicated they were from a culturally and linguistically (CALD) background, with the remaining 40% (n=4) not identifying as such.

Most clinical staff were permanent full-time employees (50% [n=5]) or permanent part-time employees (30% [n=3]), with only one casual/contractor employee (10%), and one agency or subcontractor full time employee (10%). Most were nurses and only two were PCAs. The years worked in aged care varied (see Table 5).

Table 5. RACF clinical staff demographic characteristics (N = 10)

Demographic categories	Frequency (%)
Location	
Metropolitan	6 (60%)
Regional/Rural	4 (40%)
Aboriginal and/or Torres Strait Islander	
Aboriginal	0 (0%)
Torres Strait Islander	0 (0%)
Both Aboriginal and Torres Strait Islander	0 (0%)
No	10 (100%)
Don't know	0 (10%)
CALD Background	
Yes	6 (60%)
No	4 (40%)
Employment	
Permanent Full-time	5 (50%)
Permanent Part-time	3 (30%)
Casual/Contractor	1 (10%)
Agency or sub-contractor staff – Full time	1 (10%)
Agency or sub-contractor staff – Part time	0 (0%)
Occupation	
Nurse (Nurse Practitioner / RN / EN)	8 (80%)
Personal Care Assistant	2 (20%)
Allied Health	0 (0%)
Years worked in aged care	
0-5 years	1 (10%)

5-10 years	4 (40%)
10-20 years	2 (20%)
20+ years	3 (30%)
Years worked in current role	
0-5 years	4 (40%)
5-10 years	5 (50%)
10-20 years	1 (10%)
20+ years	0 (0%)
Confidence in knowledge & skills to care for residents with IDCs	
1-3	0 (0%)
4-6	0 (0%)
7-10	10 (100%)
TOTAL	10

4.3.2 Findings

RACF staff stated the day-to-day care of people with IDCs in RACF was undertaken by PCAs who reported to ENs or RNs on catheter-related problems. Our interpretation of transcripts suggests a rule-driven approach to IDC care, with rules being set by RNs/ENs about what PCAs monitored and reported. The following comments provide insights into PCAs and RNs' understandings of their roles and responsibilities related to IDC care.

We have to monitor the [urine] output. So, we normally empty those catheters maybe three times a day (PCA)

We just help the nurse. Make sure the catheter urine is running. Make sure the colour is not different (PCA)

The PCAs job is to make sure every day we move the catheter leg bag from one leg to the other so we move it every day. So it prevents any pressure injuries (ANUM)

PCAs would only know the general sort of responsibility or care or management of IDC's. Like making sure that the bag isn't touching the floor all throughout or making sure that it's not kinked, or it's not caught anywhere. So that's in terms of the PCA responsibilities and then they report to the RN, if they feel like there's any concern in terms of the IDCs (RN).

Fear and uncertainty

Although RACF clinical staff rated their confidence in their knowledge and skills to care for residents with IDCs as seven or above on a scale of 1-10. They also expressed, however, fear and uncertainty about IDC care, coupled with a sense of being constrained in what they could, or could not do to improve care. Staff, particularly PCAs, expressed fear and concern about the risks of infection, blockage, bypassing and the potential to inadvertently remove the catheter, as illustrated by the following statements:

Oh, some of them can easily get infection if they're not looked after. Some of them getting maybe bed sores if they're not cared for well because of the bypass. ...and also like if we don't do the hygiene around the catheter. So, we have to be careful and to monitor the residents. Like any redness around, we have to communicate to the nurses (PCA).

When you're repositioning a resident, we're always scared if it [the catheter] will fall out (PCA).

Another fear about IDCs was the potential for staff to experience harm from residents who were cognitively impaired, particularly when staff attempted to change catheters or empty drainage bags. In such cases, an ANUM suggested catheter changing would be delayed.

There are a lot of times we were unable to change the catheter at the due time because of their behaviours. And with that same resident, we do have challenging times in emptying the catheter bag. Because that person can be both physically and verbally resistive, so in that situation it is very hard to empty the bag...now we are facing the problem of sediments inside the catheter where we have to do regular flushing (ANUM).

According to one PCA, being educated about IDC care would dispel fear. She said: *If you have knowledge, you have less fear.*

Barriers to IDC care

Staff described multiple interrelated factors that challenged their organisation's capacity to provide IDC care. These barriers included:

- A lack of educational preparedness for IDC care
- A deskilled RN workforce
- Arbitrary policies that restricted practice
- Inadequate clinical information

A lack of educational preparedness for IDC care

All interviewees expressed concern that education and training programs failed to equip RACF staff with the knowledge and skills required to care for residents with IDCs in RACFS. This concern applied equally to education and training programs for nurses and PCAs.

I notice from the new PCA student in here, they have never been taught about that [IDC care], which is why they have to learn things about that catheter when they work (PCA).

Clinical staff also described gaps in undergraduate nursing education that they felt caused new RNs to be unprepared to insert or change catheters.

It concerns me the level of what they get in their undergrad or what they learn just through working. It certainly doesn't teach the troubleshooting that goes on. And the skill of actually changing a catheter and all sorts of catheters (RN).

A deskilled RN workforce

Some clinical staff described a RN workforce that they said was deskilled in performing clinical procedures such as inserting and replacing catheters. They attributed this mainly to a lack of education in undergraduate nursing programs. Others felt it was due to a lack of opportunity to practice.

One challenge would be the lack of confidence for sure and the lack of confidence of nurses in terms of looking after residents with IDCs (RN)

I think a lot of nurses when they're coming out from training, don't get to see a lot of catheters. A lot of what I've actually seen is they [RNs] have to get upskilled again to even do catheter insertion (EN).

The problem of deskilling was also thought to be partially related to the fact that RACFS were able to access external clinical support from continence clinics or RIRS to change residents' catheters and address catheter-related complications, such as blockage and bypassing.

The continence clinic will do it, and it's deskilling, whereas we're trying to upskill people so that that can be passed on (CNC).

They know that RIR or any other resources are available externally, so RACFS tend to abuse that option instead of actually going in there assessing the catheter. I feel like it's the most convenient way to resolve the issue. It's also not having that accountability. So yeah, it's the easiest way out, and it doesn't fall on them (RN).

Some RNs felt that they were deskilled by not continuing to catheterise within their scope of practice and that this fuelled the stigma that nurses working in RACFS were less skilled clinicians even though as RNs “We are trained exactly the same”.

Arbitrary policies that restricted practice

Other staff described rules that limited their ability to perform catheter changes in the RACF. For example, one clinical staff member said:

All our male catheters get sent into hospital (RN).

Access to investigations, termed trial of voids to determine the ongoing medical necessity for an IDC, were also limited according to the following comment.

It's either urologist or the GP or sometimes family, but it's come to a point where the resident actually don't have any say in a trial void (RN).

Inadequate clinical information

A lack of information about the presence of the IDC or the rationale for its use was cited by some clinical staff as a barrier to IDC care. Although most residents admitted to a RACF with an IDC come from the community and had been using it for some time, others are admitted from hospital. As one RN stated:

In most cases, which I would actually say 90% of the time, the reason the IDC has been inserted is not really stated in the medical history. You might get the date it was inserted, but no other details. And sometimes it's not even in the medical history. They just come with the tube and like oh he's got IDC (RN).

Strategies/resources to support IDC care

Our analysis of clinical staff comments identified multiple factors that they believed would improve care for residents with IDCs in RACFS. They include:

- Communication processes
- Education/upskilling for staff
- RN/Manager leadership
- IDC guidelines/resources

Communication processes

Given PCAs have the closest contact with residents with IDC, staff stated that it was important to have processes in place to ensure PCAs communicated to RNs about catheter-related problems.

PCAs go straight to the RNs to gather any sort of guidance or clarification in terms of whatever they do (RN).

If there's anything to do with the bypassing and if the nurses have not seen it, we as the PCAs pass on the information to them so that they come and check it (PCA).

According to the following comment, handover times are an appropriate time for communication about the care required for residents at risk of developing problems such as encrustation. In this case, an ANUM said she asked staff to monitor a resident every hour to check on their urinary output and fluid intake and to report any 'discrepancy' to the RNs.

In each shift we make sure that whoever is included in our team on that particular day, that we will be explaining to them before they take over the care So this resident is a high risk of getting sediments in the catheter. So, you monitor their output every hour and make sure that both intake and output should be monitored, and if there is any discrepancy straight away you should come and report to us (ANUM).

Two-way communication between staff, particularly between nurses and PCAs about IDCs was considered important. The following comment from an RN highlights the importance of PCAs receiving feedback about the outcomes of their efforts to escalate or report catheter-associated complications.

And I think communication in a lot of instances between the nurses and the PCA's back and forth [is important]. The PCAs might be escalating issues. The nurses hear it, do

something about it, but don't feedback the outcomes to the PCAs. They feel undervalued and then don't help the recommendations stay in place or whatever (RN).

Education/upskilling

Interview comments suggest there is considerable variation in the availability of education for staff about IDC care. One ANUM described a comprehensive program that involved upskilling ENs in catheter insertion associated management. She said:

We train our ENs, which is very effective in our community. We have undergone education through our continence team. So, we have all competencies. We upskilled 15 ENs so they know how to do insertions and management (ANUM).

An important question for aged care providers is about the specific educational content required for education about IDC care, and how this education should vary according to the different roles and responsibilities of the team. According to one RN, PCAs need education about what to report, what they should monitor and why.

I feel like in terms of the line of reporting or like the chain of command, I think it's quite clear in my personal experience of who they need to report to and who they need to seek guidance or assistance with if they're having any sort of trouble or concerns with whatever care they're doing. It's more sort of what they need to report or what they need to be looking out for. If this is normal or this is abnormal like I said, in my experience the PCA would only know like the catheter doesn't look straight or like, I need to put the catheter in the bag and then hang it up so that it's not it doesn't stay on the floor, blah blah blah. But the principle behind it, or the rationality behind those actions, they need more knowledge in terms of that (RN).

RNs described needing access to education programs that include opportunities for clinical supervision and mentorship so that they could develop and maintain competence and confidence in the technique of inserting a catheter.

I think you've got to do a knowledge skills check and watch them [RNs] doing the actual procedure to see that they're doing it appropriately (RN).

If I had the magic wand, I would encourage, you know, nurses, RNs in particular in RACFS, to practice and to continue improving their clinical skills are applying their clinical

skills, because we have this stigma that when you are in residential aged care you don't get to practice all these clinical procedures. So that's the first thing I would do to encourage my nurses to know they are capable. They are qualified to do this (RN).

IDC education and training programs should also include a theoretical component according to a RN who consulted to RACF. She said:

Yes, we're happy to come out and, you know, go through it [the technique of IDC insertion] with somebody that hasn't done it before, but you need to have that theory component of the competency because it's not just changing a catheter, so much of it comes down to trouble shooting and care of the catheter more so than actually changing (CNC).

RN/Managerial leadership

RNs and managers have a key role to play in providing leadership on the clinical care needs of residents with IDCs according to clinical staff. At the end of the day one said, decisions about IDC care 'all come down to the RN on the floor and to clinical managers'.

I think [the training] is all forced down to first the RN on the floor because they're considered the team leaders of each wing. They're the first line of report from the PCAs and ENs. It will be up to the clinical manager as well to make sure that their RNs and ENs are up to knowledge in terms of catheter management (RN).

A RN in a leadership role described the process to identify and address any gaps in staff knowledge and skills in relation to IDC care and to minimise inappropriate referrals or outsourcing IDC care. She suggested it was important to design and implement a process to ensure RNs were equipped with the knowledge and skills to troubleshoot IDC-related complications, and to be aware of when to refer or outsource. This could involve bringing in a registered trainer.

I would set up a meeting and say where are we lacking.... where can we support you? Do you need an external registered trainer to come in and provide training and education in terms of IDC management? If that can help encourage my nurses to do more then I would definitely do that, and once they feel supported and they feel like they've had that training and they have that education, I would fall back onto my clinical manager to sort of implement. Have we done everything we could possibly do in the scope of our practice as

RNs to rectify this issue and then give them a better understanding and a structured procedure of when they can refer to RIR or to any external providers, so come up with that sort of assessment checklist. In that way, we don't sort of overuse that option and still practice our clinical, you know, skills on the floor (RN).

Similarly, another RN suggested managers should implement a policy to minimise external outsourcing IDC related problems by requiring staff to attempt to troubleshoot IDC related problems in the first instance.

I feel like managers in residential aged care should implement a procedure where we only report to a certain extent. If you've done your own troubleshooting like, give me your assessment, give me your nursing management. Give me your recommendation and give me your evaluation. If you've done those steps in your scope and in your knowledge, then it still is an issue, that's when we reach out to RIR or whoever it is from the hospital that can come in and help (RN).

IDC Guidelines

Some staff identified the need for a guideline or clinical pathway about IDC care and referred to other guidelines, such as a guideline about urinary tract infections, which they saw as helpful.

[there are] no sources of evidence for guidance about IDC care (RN).

I just think the guideline... what they [guideline developers] did with the UTI's, they need to do the same thing with catheter care (EN).

A good clinical care pathway for catheter management would be really good. [It should be] informed by urology nurses that have got a multi multidisciplinary eye. It just it needs a good pathway that complements their own policies and procedures (RN).

According to a PCA, information in the form of instructions should be in written form and easily accessible so that it can inform day-to-day care. She said:

I think the instruction in a resident's room will be better than just instruction just by mouth. Yeah, they might forget or not do the right thing or it's hard. So, we [PCAs] need the instruction in in resident's room so we can use it (PCA).

4.4 Case Study Resident Interview

4.4.1 Case study

Ms Smith (pseudonym) is a 76-year-old woman who resides in a RACF in metropolitan Melbourne. She has had an IDC for 17 months due to a neurologic condition (Multiple Sclerosis) that affected her bladder function. Ms Smith elected to have an IDC as indicated by the following comment.

Get myself to the toilet during the night. And you know, I thought there must be an easier way than this. So [getting a catheter inserted] was what I did and I must say it's been the best decision I've ever made of anything.

A catheter-related problem Ms Smith reported was bypassing which commonly occurred when she used her bowels.

I suppose the challenge is because of the bowel and the bladder being so close together.... So sometimes if I need to use my bowels that can put pressure on the bladder and a few times, not often I've had a bit of bypass.

Ms Smith's neurologic condition meant that she was dependent on staff for help to change catheter bags.

They [staff] put the day bag on and in the evening they take that off and empty it, of course, and attach the night bag. And then that hangs on my bed so that you know below the level. So that that seems to work well.

The main challenge for Ms Smith was related to obtaining the right catheter supplies. She described 'taking control of the situation' by ordering and paying for the supplies herself.

I'm taking control of the actual equipment itself. You know the bags and the catheters. I, you know, make sure that I've got a supply of what I need, because when I first had the catheter inserted and came back here, they didn't really know what supplies I needed. So, I make sure that I've got all the equipment that I need. This is more convenient than having to go and ask all the time. You know, I need this or I need that. I tend to take control of it myself (Resident).

5. DISCUSSION

This consultation was undertaken in response to a need identified by Victoria's state-based RIRS to explore the quality of care for aged care residents with an IDC. Through focus groups with 21 RIRS employees, interviews with 10 RACF clinical staff, and a survey of 28 RACF managers, we obtained insights into caring for a resident with an IDC, and the barriers to IDC care. The findings varied according to the method of data collection. In general, the survey results portrayed a positive representation of the capacity of the residential aged care sector to address the needs of residents with IDC, with minimal need for external support. However, the qualitative data presented a different scenario with the RACF workforce being described as deskilled in relation to IDC care. Specifically, RIRS employees in clinical and consulting roles and RACF clinical staff described a residential aged care sector that struggled to provide best practice IDC-care which they claimed was mainly related to a deskilled RACF nursing workforce.

The prevalence of IDC use in RACF

Based on managers' estimates, 6% of aged care residents have an IDC. This equates to 11,280 aged care residents. How this estimate compares with actual rates and with national data is unclear. Although the new Australian National Aged Care Classification (AN-ACC) funding instrument collects information about whether or not residents have an IDC, the data are not yet available. Of the 122 residents with an IDC, 75% (n=92) reportedly had a urethral catheter and 25% (n=30) had a SPC.

IDC-related complications

The findings from this consultation are consistent with international evidence suggesting aged care residents with IDCs commonly experience catheter-related problems, such as CAUTI, catheter blockage, and leakage (4-6, 19). The survey completed by managers, identified catheter blockage and bypassing as the two most common complications. Blockage is commonly due to encrustation from CAUTI. A blocked or partially blocked catheter will cause people with an IDC to experience leakage, i.e. the three issues are interrelated. **A blocked catheter and/or a leaking catheter requires urgent attention** (19). CAUTI is inevitable with an IDC, particularly a long-term IDC. This is because the IDC creates an opportunity for bacteria to enter into a person's urinary tract. CAUTI presents as either symptomatic or asymptomatic. **Symptomatic CAUTI requires urgent attention** (19).

*'When an episode of CAUTI becomes symptomatic, catheters can become blocked and people can develop symptoms such as fever, urethritis, and cystitis, acute pyelonephritis, renal scarring, calculus formation, and sepsis. **Left untreated, these infections can lead to urosepsis and death**' (19).*

Another reason it is important to respond to CAUTI is because of the risk of potentially pathogenic multidrug-resistant organisms in the RACF setting. Fifty to 75% of aged care residents receive at least one course of antimicrobials annually, but limited attention is given to antibiotic use or resistance patterns (20). About 40–75% of antibiotic use in RACF has been considered inappropriate (20). Antibiotic therapy does not prevent recurrent bacteriuria or symptomatic CAUTI. The use of antibiotics for asymptomatic bacteriuria in RACF residents with IDCs in US nursing homes is thought to be widespread (20).

Insights into the experience of living with an IDC in RACF

A key gap in our understanding about IDC care is how it is experienced by residents themselves, and the psychological impacts of living with an IDC and being dependent on RACF staff for IDC care. This is because, despite extensive recruitment efforts, only one resident participated in this consultation. IDCs, particularly urethral IDCs, are likely to threaten a person's self-esteem and sexuality (16). Moreover, IDC care is necessarily intimate and intrusive. The way that staff engage with the resident will either uphold or diminish their dignity and privacy. A particularly salient finding from our interpretive analysis of comments was the focus on catheters, rather than residents with catheters. Although participants were invited to comment on the perceived challenges for aged care residents with an IDC, apart from two comments about the potential to experience harm from residents with dementia during IDC care, no staff member identified how they interacted with residents to ensure residents' dignity was honoured. We identify the need for education about psychological approaches to IDC that protect residents' dignity and rights, and that support residents' families. This education should be informed by further research about residents' lived experience of catheterisation and care in RACF.

Insights into the experience of caring for a resident with an IDC

IDCs represent a challenge to RACF staff, providers and to RIRS. Whilst most respondents focussed on the challenges surrounding the need to replace residents' catheters regularly; they also described problems related to CAUTI, catheter blocking and leaking, the potential for residents to remove their catheter, and the potential to experience harm from residents with dementia during IDC care. Understandings about IDC care and CAUTI were limited, particularly PCAs' understandings. Our analysis of interview data suggests many RACF staff are fearful and uncertain about IDC care, especially about possible complications. The fear of catheter blockage causes RNs to place considerable pressure on PCAs to regularly check, monitor and report on residents' urinary output and to ensure residents' catheters are appropriately positioned and patent.

The challenge RIRS employees identified was the demand from RACF to support them to deliver routine uncomplicated IDC care that they believed was within the scope of practice and educational expertise of RNs. Respondents identified variability in RNs' competence and confidence to change catheters for residents with an

IDC or troubleshoot catheter-related complications such as CAUTI, blockage and bypassing. They consistently described RNs as 'deskilled' in clinical practice.

Our interpretive analysis of staff comments points to different understandings about RNs' scope of practice in relation to IDC care. Although 61% of managers stated they had a policy or protocol that allowed RNs to catheterise male residents, many respondents believed that the clinical procedure was not within a RN's scope of practice. In some cases, this belief is reinforced by a medical practitioner or provider. It should be noted that the insertion of a catheter into a male follows the same principles as for a female. Nursing education programs equip RNs with clinical assessment skills to conduct an assessment prior to catheterising any person: male or female. One aspect of this assessment involves identifying indications and contraindications to the insertion of a catheter.

Many respondents also believed that it was not within a RN's scope of practice to insert or remove a suprapubic catheter. Although 89% of managers stated their organisation allowed RNs to insert a catheter, the question did not differentiate between urethral and suprapubic catheterisation. Therefore, the extent to which RACFs support RNs to perform a suprapubic catheter change vis-a vis a urethral catheter change is unknown. Qualitative findings indicate that there is considerable angst and uncertainty about who is responsible for inserting and removing SPCs in RACFs. With the exception of services like RIR, there are no consistent or funded pathways or mechanisms for residents with IDCs (urethral or SPC) to access specialist support, such as urological or continence support to address IDC related problems. This gap in care warrants further attention at a policy level.

RNs' scope of practice

In Australia, the Nursing and Midwifery Board of Australia (NMBA) regulates the practice of nursing and midwifery. The NMBA Standard for Practice for RNs (21) requires RNs to maintain their capability to practice as regulated health professionals and indicates they are responsible and accountable for ensuring they are safe and have the capability for practice. RNs are accountable for the management of people in their care. If they do not have the knowledge and skills to meet the health needs of the people they serve, they have a responsibility to develop their scope of practice and capabilities. ***RNs are responsible for their own professional development.***

It is important to note that all aspects of urethral urinary catheter insertion for men and for women and management of urethral and suprapubic catheters are within the scope of practice of a RN. Undergraduate nursing programs provide nurses with the knowledge and skills required to perform urinary catheterisation and care for a person with an IDC. However, the gaps identified in this consultation suggest many RNs working in the aged care sector do not feel confident to perform urinary catheterisation, change a SPC, nor assess and manage the issues that commonly occur with long term catheterisation. This finding aligns with previous research highlighting gaps in RNs' knowledge, confidence and decision-making related to inserting a catheter, troubleshooting catheter-associated complications, and educating others about catheter care, and overall IDC care (11-15).

There may be multiple reasons for RNs' apparent lack of capability to deliver IDC care in RACF. Indeed, clinical staff and RIR staff claimed undergraduate programs were unlikely to adequately equip RNs with the requisite knowledge and skills. Shorter lengths of patient stay and the use of fewer catheters in hospitals have reduced student nurses' opportunities to perform urinary catheter insertion. And the experience they gain is most likely to be related to short-term catheterisation, not suprapubic or long-term catheterisation. This means fewer nurses are entering practice with the requisite clinical expertise. A lack of clinical mentorship and opportunity to practice IDC insertion in RACFs was also cited as a cause of deskilling in RACFs. Unlike hospital settings, nurses working in RACFs have limited access to support from senior nursing leaders who can observe and supervise them to consolidate their clinical skills and scope of practice. Although there are multiple courses available to nurses to increase their knowledge about IDC care, what is missing from the RACF sector is a funded mechanism for nurses to access urological or continence clinical expertise to consolidate this knowledge and build their confidence in clinical interventions.

Other possible reasons for the apparent deskilling could relate to a lack of evidence or guidance about how to care for people with long-term IDCs. Whilst this evidence-based knowledge exists, it is not always readily available and accessible to staff working in direct clinical care roles. Deskilling is likely to be reinforced by local policies and procedures that discourage RNs from upskilling and from functioning within the full scope of their practice.

Impact of variable understandings of RN's scope of practice

Variability in RNs' capabilities to deliver IDC care in RACF has several potential impacts. Firstly, it could impact on residents' access to timely interventions which increases their risk of death. Secondly, it could create an incentive for providers to outsource IDC care to external agencies/individuals, such as RIRS or hospitals, which exacerbates the problem of a lack of clinical leadership and skill within RACF. Variable understandings about an RN's scope of practice result in inconsistencies in IDC related care, with some residents having to go to ED or wait for the RIRS to attend to them or wait until a 'competent' RN was available – as indicated by the following comments.

One problem is bypassing. Sometimes if there's no competent RN on the floor, residents will wait.

Quite sad to see that a lot of the residents have to wait for their IDC or SPC to be changed.

The findings also identify other areas for improvement. For example, the lack of communication about the presence and medical rationale for IDCs from hospitals reported by a clinical staff member is concerning. At the same time, most survey respondents indicated their documentation included information about the medical reason for residents' catheters. Another potential area for standardisation or consistency is in ensuring RACF have a supply of catheter-related equipment on hand at all times. The fact that the one and only resident who

participated in this consultation stated she preferred to pay for her own equipment in order to ensure she obtains the right supplies is concerning.

5.1 Limitations

One of the main considerations in interpreting the findings from this consultation is that, despite a major recruitment effort, the response rate to the managers' survey was very low and therefore the data are likely to represent a biased sample of respondents. We aimed to recruit 114 managers from Victorian RACF to complete the survey. The final sample was 28 (24%). Standards for survey research typically require response rates approximating 60-80% (22). Our response rate is consistent with that of a recent postal survey to 766 Victorian RACF managers to establish the nature of social participation opportunities available to residents, where researchers reported a 20% response (23).

The low response rate to the managers' survey may partially explain the differences between the findings of the survey for managers and the findings from interviews with staff. Although the survey was anonymous, and managers had the option to opt out of responding to specific questions, given the sensitive nature of the topic and the inherent pressure on managers to present themselves favourably with respect to current aged care norms and standards, the survey responses are likely to represent social desirability response bias. According to seminal research (24), between 10% and 75% of the variance in participants' responses can be explained by social desirability response which can confound relationships among the variables of interest by suppressing or obscuring relationships among variables or producing artificial relationships between variables (25). There is considerable pressure on providers of aged care providers and employees to avoid negative evaluation or judgment. Research efforts to minimise this type of bias are required.

It is also important to note that whilst mixing two methods can be superior to a single method as it is likely to provide rich insights into the research phenomena that cannot be fully understood by using only qualitative or quantitative methods, triangulating conflicting results from the different approaches is challenging. This consultation produced conflicting results. This is the case for most mixed-methods research (26). Hence, there is a challenge in relating the two different kinds of information and drawing a definitive conclusion from them (27). We identified IDC care in RACF as a particularly complex problem that warranted the application of a mixed methods approach in the first instance. The approach yielded insights into the complexity of this problem, but clearly, further research is warranted in order to definitively answer questions about the quality of IDC care – and particularly, about residents' experiences.

Our aim was to obtain rich insights from residents about their experiences of living with an IDC and their experiences of care. However, only one resident volunteered to participate. However, it is well established that very old people participate less often in social surveys than younger age-groups (28). There are several reasons for lower rates in older people, but in very old persons, a low health status inhibits survey participation, as does living in an institution (28). As data from one person is unlikely to represent the range of experiences, the interview data was presented as a case study. In terms of recommendations for accessing this type of

information for future research, there is a need to rethink how to reach residents in the first instance. Prior experience conducted by NARI suggests there are multiple gatekeepers and barriers to residents' engagement in research (29). As part of the Commonwealth Governments reform agenda to put older people at the heart of the aged care system, aged care providers are required to adopt a range of best practice strategies to promote consumer engagement (30). This engagement should be extended to engagement in, and with research. Currently the lived experiences of older people in RACF are underrepresented in research. This includes the voices and experiences of the 6% of older people in RACF who have an IDC.

It should also be noted that the consultation was promoted in English language. Hence, although interpreters were available, a lack of English language recruitment materials may have resulted in the exclusion of linguistically diverse people and hence, selection bias was likely to be introduced.

6. CONCLUSION

The mixed method approach used in the consultation identified a disconnect between what managers reported about IDC care and capability and what clinical staff and RIR employees reported. Therefore, the actual quality of care residents with IDCs in RACF receive is unclear. The findings point to the need for a multifaceted approach to identify and comprehensively identify and address the care needs of aged care residents with IDCs. We suggest a starting point would be to establish systems and processes to systematically collect information about rates of IDC use, associated complications, and how they are managed in RACF. This should be accompanied by assessment and review processes that ensure the clinical appropriateness of individual IDCs in RACF. Wherever possible, IDCs should be removed.

Delays in responding to residents with symptomatic CAUTI or catheter blockage increase residents' risks of dying. These risks could be minimised if RACF staff were confident and competent in IDC care. It is incumbent on aged care providers to ensure that the staff they employ have the knowledge and skills to provide safe, respectful IDC care. Recruitment programs should emphasise the importance of RNs' having relevant and contemporary clinical expertise.

Our findings also point to possible gaps in education for nurses and PCWs about the care associated with having a long-term indwelling catheter and about suprapubic catheterisation. There is a need to review accredited education and training programs for the aged care workforce to ensure the content addresses IDC care. This education should extend to PCAs who have the greatest day-to-day contact with residents. Given IDC care is taught in undergraduate nursing programs, further attention should be given to upskilling and maintaining RNs' competence and confidence to maintain and develop their clinical skills in RACF. Training and education programs should include information about how to: (i) insert, remove and replace routine uncomplicated catheters; (ii) identify, minimise and troubleshoot IDC-associated complications, (iii) differentiate between symptomatic and asymptomatic CAUTI, (iv) identify signs and symptoms that warrant referral and immediate attention, and (v) identify and address the information and support needs of residents, families and other staff.

Finally, the psychological impact of having an IDC has received scant attention in research, policy or practice. The presence of an IDC is likely to impact on a person's wellbeing. Staff's focus on the technical challenges for staff in caring for residents with IDCs suggested limited awareness in the psychological impacts for residents and/or the information and support needs of residents' families. There is a need to develop evidence-informed psychological interventions that support residents with an IDC to psychologically live well.

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APPENDICES

Appendix 1. Recruitment Flyer: Focus Group



NARI NATIONAL AGEING RESEARCH INSTITUTE

IMPROVING CARE FOR PEOPLE WITH INDWELLING CATHETERS IN RESIDENTIAL AGED CARE

5 -8% of people in Victorian residential aged care homes have an in-dwelling catheter (IDC) for bladder management. The National Ageing Research Institute is leading a consultation to understand care associated with IDCs.

NARI invites you to take part in a focus group consultation of residential-in-reach staff to discuss about your experience with indwelling catheter (IDC) care in residential aged care.

The focus group will take place online on Thursday 20th April 2023 at 1:00-2:00PM AEST.

If you would like to participate, or know more about the consultation, please contact Isabella Hall at i.hall@nari.edu.au or reception on (03) 8387 2305.

We are currently recruiting:

Residential-in-Reach
Service staff

.....

Online focus group

.....

Thursday 20th April 2023
1:00 - 2:00PM AEST

.....

To register your interest, please contact:
Isabella Hall
i.hall@nari.edu.au
or
Reception
(03) 8387 2305



Appendix 2. Recruitment Letter of Invitation: Focus Group



Letter of invitation –focus group

Invitation to take part in a research project:

Your experiences and expectations about indwelling urinary catheter care in residential aged care.

Dear <insert name>

The National Ageing Research Institute (NARI) wants to hear from residential-in reach staff about your experience with indwelling catheter (IDC) care in residential aged care.

We aim to obtain insights into the experience of living with an IDC in residential aged care homes (RACs) and the barriers to receiving care.

The focus group will take approximately 60 minutes and will take place online at a time that is convenient for the participants in May 2023.

You will be given a gift card in appreciation of your time.

If you are interested in participating in a focus group, or if you have questions about the project, please contact [myself](#) at j.ostaszkiewicz@nari.edu.au for further information. Expressions of interest will close on <insert date> 2023.

Thank you for considering participating in this project.

Kind regards,

Dr Joan Ostaszkiewicz
National Ageing Research Institute

The Bellberry Human Research Ethics Committee has reviewed and approved this study in accordance with the National Statement on Ethical Conduct in Human Research (2007) – incorporating all updates. This Statement has been developed to protect the interests of people who agree to participate in human research studies. Should you wish to discuss the study or view a copy of the Complaint procedure with someone not directly involved, particularly in relation to matters concerning policies, information or complaints about the conduct of the study or your rights as a participant, you may contact the Operations Manager, Bellberry Limited on 08 8361 3222.

Appendix 3. Participant Information and Consent Form: Focus Group

Participant Information Sheet/Consent Form for Focus Groups

Health/Social Science Research - Adult providing own consent

National Ageing Research Institute

Title	<i>A consultation about catheter care and associated complications for older people in Victorian residential aged care homes</i>
Protocol Number	<i>Bellberry 2023-01-027</i>
Project Sponsor	<i>Victorian Department of Health</i>
Principal Investigators	<i>Dr Joan Ostaszkiewicz</i> <i>Prof Briony Dow</i>
Associate Investigators	<i>A Prof Frances Batchelor</i> <i>Dr Jessica Cecil</i> <i>Ms Marie Vaughan</i>
Location	<i>National Ageing Research Institute</i>

Part 1 What does my participation involve?

1 Introduction

Thank you for your interest in participating in this National Ageing Research Institute (NARI) research project, “A consultation *about catheter care and associated complications for older people* in Victorian residential aged care homes”. You have been invited because you are;

- A Residential-in-reach service staff member currently working at a Victorian residential aged care facility

This Participant Information Sheet/Consent Form tells you about the research project. It explains the processes involved with taking part. Knowing what is involved will help you decide if you want to take part in the research.

Please read this information carefully. Ask questions about anything that you don't understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or local health worker.

Participation in this research is voluntary. If you don't wish to take part, you don't have to.

If you decide you want to take part in the research project, you will be asked to provide verbal consent prior to the focus group commencing. Alternatively, you may sign the attached consent form and email or mail the form to the research team listed on page 5 using the postage paid reply envelope required (please keep a copy for yourself if desired).

By providing verbal or written consent you are telling us that you:

- Understand what you have read
- Consent to take part in the research project
- Consent to be involved in the research described
- Consent to the use of your personal and health information as described.

Please keep this Participant Information and Consent Form.

2 What is the purpose of this research?

Your ideas and input will be used by the National Ageing Research Institute (NARI) to develop a report for the Department of Health that will represent the views of the different stakeholder groups and will include specific and targeted recommendations to address the care needs of aged care residents with an in-dwelling catheter (IDC) in Victorian residential aged care homes.

3 What does participation in this research involve?

Should you agree to participate you will be asked to attend one online or face-to-face focus group (depending on the availability of staff and Covid19 restrictions). We anticipate the focus group to be in held the morning, with tea breaks lasting about 3 hours (half-day workshop).

You will be invited to share your experiences of providing support to residential aged care about IDC care, your perceptions of challenges for residents and staff, staff roles, responsibilities and capabilities related to IDC care, and the structures and processes required to minimise and manage IDC-related complications.

There are no right or wrong answers to the questions that will be asked. The researchers are just interested in your opinions.

If you agree, the focus group will be audio-taped. Written records will also be taken, in addition to the audio-recording. The purpose of the audio and written notes is to assist the researchers (at the conclusion of the workshop) to examine the issues that were raised. The information provided will not in any way be used to identify individuals, and only members of the research team will have access to the recordings. This research project has been designed to make sure the researchers interpret the results in a fair and appropriate way.

There are no costs associated with participating in this research project.

4 Other relevant information about the research project

Focus groups will aim to be limited to fifteen participants, to enable effective discussion.

5 Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. This can be done by contacting one of the researchers listed below.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your employment status.

6 What are the possible benefits of taking part?

There will be no direct benefit to you from your participation in this research; however, by participating in the project you have the ability to influence a final report and target recommendations to address the care needs of aged care residents with an IDC in Victorian residential aged care. This report will be provided to the Victorian Department of Health.

7 What are the possible risks and disadvantages of taking part?

It is possible that participating in the workshop and talking about the topic of IDC care may cause distress to some people. If you do not wish to answer a question, you may skip it and go to the next question, or you may stop immediately. The NARI researchers are qualified and experienced in facilitating focus groups and will be able to provide you with support and information if you need it. If you become upset or distressed as a result of your participation in the research project, the facilitators will offer to stop the focus group and advise you to seek medical support from your GP if you remain distressed. All care will be taken to maintain your privacy and confidentiality.

8 What if I withdraw from this research project?

If you do consent to participate, you may withdraw at any time. If you decide to withdraw from the project, please notify a member of the research team below.

If you decide to leave the research project, the researchers will not collect additional personal information from you. You should be aware that data collected up to the time you withdraw will form part of the research project results. If you do not want your data to be included, you must tell the researchers when you withdraw from the research project. At your request, any identifying information that the researchers have about you will be destroyed.

9 Could this research project be stopped unexpectedly?

This research project is unlikely to be stopped unexpectedly but may be terminated, reduced in scope or otherwise influenced by changes in the Victorian Department of Health's priorities.

10 What happens when the research project ends?

The results of this study will be provided directly to participants who indicate they would like to see the research outcomes and provide a valid email or postal address to researchers.

Part 2 How is the research project being conducted?

11 What will happen to information about me?

By providing verbal or written consent you consent to the research team collecting and using personal information about you for the research project. Any information obtained in connection with this research project that can identify you will remain confidential and securely stored as identifiable and re-identifiable data. Hard copy data will be stored in a locked filing cabinet and computer files will be password protected. Only members of the research team will have access to this data. You should note that these measures are only able to guarantee confidentiality within the limits of the law. All data collected in this project will be kept for seven years following completion of the study, and then be destroyed. Your information will only be used for the purpose of this research project and it will only be disclosed with your permission, except as required by law. You will not be identified in any publication, or data that results from this research project. Your confidentiality will be protected as we will report group data only. When using quotes from interviews only your age, gender and role) will be recorded. The Victorian Department of Health will receive regular anonymised reports about the

research project and at the conclusion. The researchers will also publish the anonymised findings in peer review journals and at scientific conferences that target the continence and aged care workforce.

In accordance with relevant Australian and Victorian privacy and other relevant laws, you have the right to request access to the information about you that is collected and stored by the research team. You also have the right to request that any information with which you disagree be corrected. Please inform the research team member named at the end of this document if you would like to access your information.

12 Who is organising and funding the research?

This research project is being funded by the Victorian Department of Health.

No member of the research team will receive a personal financial benefit from your involvement in this research project (other than their ordinary wages).

13 Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC).

The Bellberry Human Research Ethics Committee has reviewed and approved this study in accordance with the National Statement on Ethical Conduct in Human Research (2007) – incorporating all updates. This Statement has been developed to protect the interests of people who agree to participate in human research studies. Should you wish to discuss the study or view a copy of the Complaint procedure with someone not directly involved, particularly in relation to matters concerning policies, information or complaints about the conduct of the study or your rights as a participant, you may contact the Operations Manager, Bellberry Limited on 08 8361 3222.

14 Further information and who to contact

The person you may need to contact will depend on the nature of your query. If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact the responsible researcher on 0414 975 440 or any of the following people:

Research contact person

Name	<i>Dr Joan Ostaszekiewicz</i>
Position	<i>Director Aged Care Division, NARI</i>
Telephone	<i>0414 975 440</i>
Email	<i>j.ostaszekiewicz @nari.edu.au</i>

Name	<i>Ms Marie Vaughan</i>
Position	<i>Research Fellow, NARI</i>
Telephone	<i>0488 363 155</i>
Email	<i>i.hall @nari.edu.au</i>

Mailing Address	<i>NARI PO Box 2127 Royal Melbourne Hospital Victoria 3050 Australia</i>
-----------------	--

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

Reviewing HREC approving this research and HREC Executive Officer details

Reviewing HREC name	<i>Bellberry Limited</i>
HREC Executive Officer	<i>Operations Manager</i>
Telephone	<i>08 8361 3222</i>
Email	<i>bellberry@bellberry.com.au</i>

Consent Form - Adult providing own consent

Title *A consultation about catheter care and associated complications for older people in Victorian residential aged care homes*

Protocol Number *Bellberry 2023-01-027*

Project Sponsor *Victorian Department of Health*

Principal Investigator *Dr Joan Ostaszewicz*

Associate Investigators *Prof Briony Dow
A Prof Frances Batchelor
Dr Jessica Cecil
Ms Marie Vaughan
Ms Isabella Hall*

Location *National Ageing Research Institute*

Declaration by Participant

I have read the Participant Information Sheet or someone has read it to me in a language that I understand.

I understand the purposes, procedures and risks of the research described in the project.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project.

I understand that I will be given a signed copy of this document to keep.

☐

Verbal Consent provided

Name of Participant (please print) _____

Signature _____ Date _____

Declaration by Researcher[†]

I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Name of Researcher[†] (please print) _____

Signature _____ Date _____

[†] An appropriately qualified member of the research team must provide the explanation of, and information concerning, the research project.

Note: All parties signing the consent section must date their own signature

Form for Withdrawal of Participation - *Adult providing own consent*

Title *A consultation about catheter care and associated complications for older people in Victorian residential aged care homes*

Protocol Number *Bellberry 2023-01-027*

Project Sponsor *Victorian Department of Health*

Principal Investigator *Dr Joan Ostaszewicz*

Associate Investigators *Prof Briony Dow
A Prof Frances Batchelor
Dr Jessica Cecil
Ms Marie Vaughan
Ms Isabella Hall*

Location *National Ageing Research Institute*

Declaration by Participant

I wish to withdraw from participation in the above research project and understand that such withdrawal will not affect my employment, or my relationships with the researchers or the National Ageing Research Institute

Name of Participant (please print) _____

Signature _____ Date _____

In the event that the participant's decision to withdraw is communicated verbally, the Senior Researcher must provide a description of the circumstances below.

Declaration by Researcher[†]

I have given a verbal explanation of the implications of withdrawal from the research project and I believe that the participant has understood that explanation.

Name of Researcher (please print) _____

Signature _____ Date _____

[†] An appropriately qualified member of the research team must provide information concerning withdrawal from the research project.

Note: All parties signing the consent section must date their own signature.

Appendix 4. Recruitment Invitation of Letter: RACF Manager Survey

Invitation to take part in a research project

Your experiences and expectations about indwelling urinary catheter care in residential aged care.

Dear Facility Manager,

The National Ageing Research Institute (NARI) wants to hear from you, as a manager of a Victorian residential aged care home, about your experience with indwelling catheter (IDC) care in residential aged care.

We aim to obtain insights into the number of residents with an IDC, the proportion who have experienced problems, the nature of the problems, the number of referrals to the RIRS for IDC-related complications, the number of admissions to emergency departments for IDC-related complications and reasons for IDC use, resources and supporting services available to them, and their confidence about staff capabilities to care for residents with IDCs.

The survey will be anonymous and can be completed at a time convenient to you. You will go into the draw to receive a gift card in appreciation of your time.

If you are interested in participating, please follow the link below to take part:

<https://redcap.nari.edu.au/redcap/surveys/?s=YXMYH3XJYYMCNNH4>

If you have questions about the project, please contact me at j.ostaszkiewicz@nari.edu.au for further information. The opportunity to participate in the survey will close on 30th June 2023.

Thank you for considering participating in this project.

Kind regards,

Dr Joan Ostaszkiewicz

National Ageing Research Institute

The Bellberry Human Research Ethics Committee has reviewed and approved this study in accordance with the National Statement on Ethical Conduct in Human Research (2007) – incorporating all updates. This Statement has been developed to protect the interests of people who agree to participate in human research studies. Should you wish to discuss the study or view a copy of the Complaint procedure with someone not directly involved, particularly in relation to matters concerning policies, information or complaints about the conduct of the study or your rights as a participant, you may contact the Operations Manager, Bellberry Limited on 08 8361 3222.

Appendix 5. Social Media Plan

To assist with participant recruitment for “A consultation about catheter care and associated complications for older people in Victorian residential aged care homes”, The National Ageing Research Institute (NARI) will utilise social media and digital resources.

Social media advertising will consist of text posts, which may be accompanied by stock images or images owned by NARI, as well as the distribution of recruitment flyers. The image below shows an example of social media posts. Posts will be created by the research team via the social media management software, Buffer. The recruitment flyers for Residential-in-Reach Service staff, resident interviews, and staff interviews will invite potential participants to contact the research team via email to express their interest in participating. The recruitment flyer for managers of Residential Aged Care Homes (RAC) will provide a direct link to the survey. These posts and flyers will be displayed across the following social media platforms:

- Twitter (@NAgeingRI)
- Facebook (NatAgeingResearch)
- LinkedIn (National Ageing Research Institute)
- The official NARI website (nari.net.au)

See the table below for a draft social media schedule.

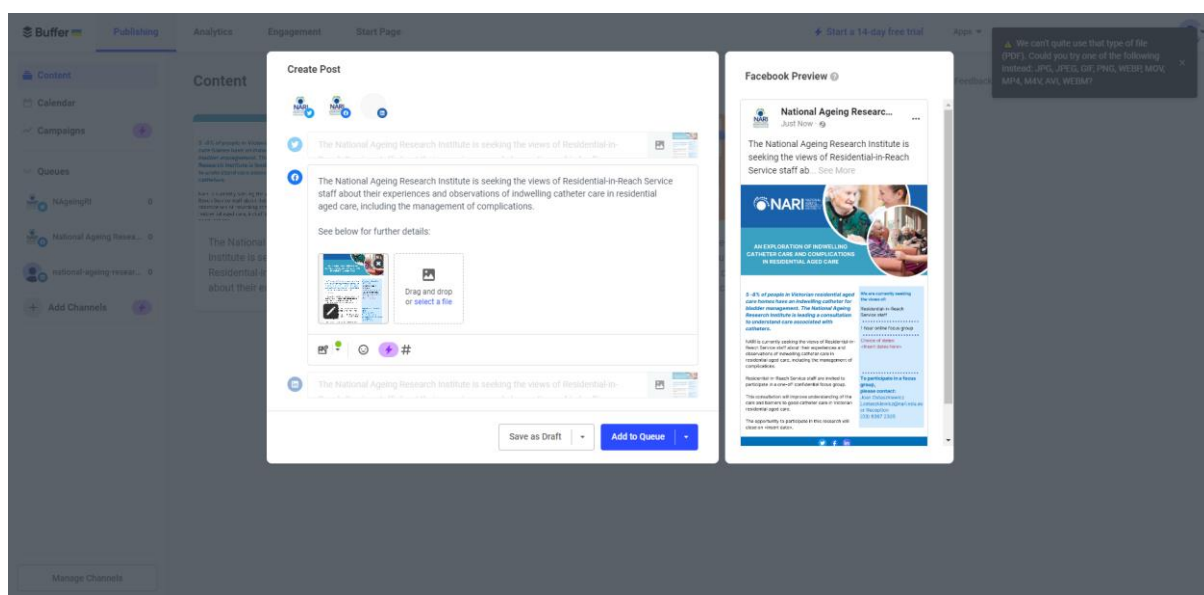
Organisations that have a key role to play in providing support and information to the aged care sector will be emailed about the project and invited to share or retweet the posts. These organisations include but are not limited to:

- Carers Victoria
- Older Persons Advocacy Network
- The Austin
- Bolton Clarke
- Senior Rights Victoria
- Australian Primary Health Care Nurses Association
- Australian Nursing and Midwifery Association
- National Aged Care Alliance
- Elder Rights Advocacy
- SaferCare Victoria

The project team will monitor NARI’s social media. In instances of participants reaching out to the NARI social media platforms about this consultation, the Research Assistant (RA) will assess their eligibility to participate in the research based on whether they belong to any of the key populations being sampled (Residential In-Reach Service staff, managers of Victorian RACs, clinical staff of Victorian RACs, Victorian residents of RACs, with current IDCs or IDCs within the past 12 months).

Public comments on NARI social media posts relating to this consultation will not be encouraged, and any public comments made by viewers will be voluntary. Viewers will be encouraged to contact the RA by email or NARI reception by phone to protect the privacy and confidentiality of potential participants. The collection of any personal information via social media will be saved to password protected computer systems at NARI and subsequently removed from the social media platform.

Example social media post



Draft social media schedule

Date of post	Platforms	Text	Image
May 3rd 2023	Twitter, Facebook, LinkedIn	The National Ageing Research Institute is seeking the views of Residential-in-Reach Service staff about their experiences and observations of indwelling catheter care in residential aged care, including the management of complications. See below for further details:	Recruitment flyer focus group
May 10th 2023	Twitter, Facebook, LinkedIn	Are you a manager of a Victorian Residential Aged Care home? We are interested in hearing from managers about the frequency and severity of catheter related complications and how they are currently managed. For more details on this anonymous survey, please see below:	Recruitment flyer survey
May 17th 2023	Twitter, Facebook, LinkedIn	NARI invites clinical staff of Residential Aged Care homes to share their experiences and observations of indwelling catheter care in residential aged care, including the management of complications.	Recruitment flyer interview staff

		See below for information on how to share your views:	
May 24th 2023	Twitter, Facebook, LinkedIn	Do you live in a Residential Aged Care home and have a catheter? NARI invites you to share your experiences about the care you receive. See below for more information on how to share your views:	<i>Recruitment flyer interview residents</i>
May 31st 2023	Twitter, Facebook, LinkedIn	Re-tweet/quote tweet/share previous post from May 10th	
June 7th 2023	Twitter, Facebook, LinkedIn	Re-tweet/quote tweet/share previous post from May 17th	
June 14th 2023	Twitter, Facebook, LinkedIn	Re-tweet/quote tweet/share previous post from May 24th	

Appendix 6. Recruitment Flyer: RACF Manager Survey



AN EXPLORATION OF INDWELLING CATHETER CARE AND COMPLICATIONS IN RESIDENTIAL AGED CARE

5 -8% of people in Victorian residential aged care homes have an indwelling catheter for bladder management. The National Ageing Research Institute is leading a consultation to understand care associated with catheters.

NARI invites residential aged care home managers to take part in an **anonymous online survey** on the frequency and severity of catheter related complications and how they are currently managed.

This consultation will improve understanding of the care and barriers to good catheter care in Victorian residential aged care.

If you would like to know more about the survey, please contact Joan Ostaszkiewicz
j.ostaszkiewicz@nari.edu.au or reception on
(03) 8387 2305.

The opportunity to participate in this research will close on <insert date>.

We are currently recruiting:

Managers of Residential
Aged Care Homes

.....

To participate in:

15 minute online
anonymous survey

.....

**<Insert QR Code
Here>**

<Insert link here>



Appendix 7. Revised Communications Strategy

Steps	Platforms	Text	Image/Links
1.	NARI Website	"NARI website IDC-Consult Project"	<i>IDC-Consult project flyer</i> <i>Microsoft forms registration of interest link</i>
2.	Email	Dear ..., To better understand the clinical risks associated with indwelling catheters in Victorian residential aged care homes, the National Ageing Research Institute is extending consultation feedback timelines to seek the views of: • Aged care residents' with an indwelling catheter • Staff members' caring for residents with catheters • Managers responsible for minimising risks associated with catheter use To have your say, click here. NB: Thanks to feedback, we have resolved technical issues with the survey.	<i>IDC-Consult project flyer</i> <i>Microsoft forms registration of interest link</i>

		For more information: <insert website link>, or contact Caitlin Tay, c.tay@nari.edu.au . Kind regards,	
3.	Facebook, LinkedIn, Twitter	Take part in a project to better understand the clinical risks associated with indwelling catheters in Victorian residential aged care homes. See below for more information:	<i>IDC-Consult project flyer</i>
4.	<i>Residents/staff/managers fill in Microsoft registration of interest form</i>		
5.	Email	"Email communication_resident 24072023"	<i>Resident Interview PICF <u>and</u> Plain Language Statement</i>
6.	Email	"Email communication_staff 24072023"	<i>Staff Interview PICF <u>and</u> Plain Language Statement</i>

Appendix 8. Updated Recruitment Flyer: RACF Manager Survey, Staff and Resident Interviews



5-8% of people living in a residential aged care home have an indwelling catheter



Share your learnings and experiences about catheter care in Victorian residential aged care homes



To register, please scan the QR code, or visit:
<https://forms.office.com/r/5akHfDVTLf>

NARI IS RESEARCHING:



Residents' experiences of having an indwelling catheter



Staff members' experiences of caring for residents with catheters



Managers' experiences of minimising risks associated with catheter use

Appendix 9. Recruitment Flyer: RACF Resident Interviews



5 -8% of people in Victorian residential aged care homes have an indwelling catheter for bladder management. The National Ageing Research Institute is leading a consultation to understand care associated with catheters.

NARI is looking to hear from residents who currently have a catheter, or have had a catheter removed in the last 12 months to take part in an interview about their experiences and the care they receive.

Interviews will be conducted online or via phone and all responses will be kept confidential. If residents wish to do so, they may invite a support person.

This consultation will improve understanding of the care and barriers to good catheter care in Victorian residential aged care.

The opportunity to participate in this research will close on <insert date>.

We are currently seeking the views of:

Residents of Victorian Residential Aged Care Homes:

- With a current catheter
- With catheter removed in the last 12 months

.....

30-60 minute interview at a time that suits you

.....

To share your views, please contact:

Joan Ostaszekiewicz
j.ostaszekiewicz@nari.edu.au
or Reception
(03) 8387 2305



Appendix 10. Recruitment Flyer: RACF Staff Interviews



AN EXPLORATION OF INDWELLING CATHETER CARE AND COMPLICATIONS IN RESIDENTIAL AGED CARE

5 -8% of people in Victorian residential aged care homes have an indwelling catheter for bladder management. The National Ageing Research Institute is leading a consultation to understand care associated with catheters.

NARI is currently seeking the views of clinical staff about their experiences and observations of indwelling catheter care in residential aged care, including the management of complications.

Staff are invited to participate in a one-off confidential interview. Interviews will be conducted online or via phone and all responses will be kept confidential.

This consultation will improve understanding of the care and barriers to good catheter care in Victorian residential aged care.

The opportunity to participate in this research will close on <insert date>.

We are currently seeking the views of:

Clinical staff of
Residential Aged Care
Homes

.....

To participate in:

30-60 minute interview

.....

**To share your views,
please contact:**

Joan Ostaszkiewicz
j.ostaszkiewicz@nari.edu.au
or Reception
(03) 8387 2305



Participant Information Sheet/Consent Form for Resident Interviews

Health/Social Science Research - Adult providing own consent

National Ageing Research Institute

Title	<i>A consultation about catheter care and associated complications for older people in Victorian residential aged care homes</i>
Protocol Number	<i>Bellberry 2023-01-027</i>
Project Sponsor	<i>Victorian Department of Health</i>
Principal Investigators	<i>Dr Joan Ostaszkiewicz</i>
Associate Investigators	<i>Prof Briony Dow A Prof Frances Batchelor Dr Andrew Gilbert Ms Marie Vaughan Ms Caitlin Tay</i>
Location	<i>National Ageing Research Institute</i>

Part 1 What does my participation involve?

1 Introduction

Thank you for your interest in participating in this National Ageing Research Institute (NARI) research project, “A consultation *about catheter care and associated complications for older people* in Victorian residential aged care homes”. You have been invited because you are a resident living in a Victorian residential aged care facility who currently has an in-dwelling catheter (IDC) or has had an in-dwelling catheter (IDC) in the last 12 months.

This Participant Information Sheet/Consent Form tells you about the research project. It explains the processes involved with taking part. Knowing what is involved will help you decide if you want to take part in the research.

Please read this information carefully. Ask questions about anything that you don’t understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or local health worker.

Participation in this research is voluntary. If you don't wish to take part, you don't have to.

If you decide you want to take part in the research project, you will be asked to provide verbal consent prior to the interview commencing. Alternatively, you may sign the attached consent form and provide it to the research team in person or via email or mail (see contact details on Pg 5). Please keep a copy for yourself if desired.

By providing verbal or written consent you are telling us that you:

- Understand what you have read
- Consent to take part in the research project
- Consent to be involved in the research described
- Consent to the use of your personal and health information as described.

Please keep this Participant Information and Consent Form.

2 What is the purpose of this research?

Your ideas and input will be used by the National Ageing Research Institute (NARI) to develop a report for the Department of Health that will represent the views of the different stakeholder groups and will include specific and targeted recommendations to address the care needs of aged care residents with an in-dwelling catheter (IDC) in Victorian residential aged care homes.

3 What does participation in this research involve?

Should you agree to participate you will be invited to participate in a face-to-face interview with a researcher, lasting approximately 30-60 minutes. You may choose to have a support person present during the interview process, an interpreter or other cultural aids or supports such as an advisor.

If you agree, the interview will be audio-taped. Written records will also be taken, in addition to the audio-recording. The purpose of the audio and written notes is to assist the researchers (at the conclusion of the interview) to examine the issues that were raised. The information provided will not in any way be used to identify individuals, and only members of the research team will have access to the recordings. This research project has been designed to make sure the researchers interpret the results in a fair and appropriate way.

During the interview you will be asked about:

- Demographic information (age, gender etc.)
- Your reason for participating
- You will be invited to share your experiences of living with an IDC, the impact on your life, the challenges you may or may not have experienced with your IDC, the strategies you employ to minimise and manage complications, how IDC-related complications are managed, and your satisfaction with the care you receive to minimise and manage these complications.

There are no right or wrong answers to the questions that will be asked. The researchers are just interested in your opinions and perspectives.

There are no costs associated with participating in this research project. You will receive a \$40 gift card in recognition of your time.

5 Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. This can be done by contacting one of the researchers listed below. Alternatively, you may advise the residential manager to contact the research team on your behalf. Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your residential rights or care.

6 What are the possible benefits of taking part?

There will be no direct benefit to you from your participation in this research; however, by participating in the project you have the ability to influence a final report and target recommendations to address the care needs of aged care residents with an IDC in Victorian residential aged care. This report will be provided to the Victorian Department of Health.

7 What are the possible risks and disadvantages of taking part?

It is possible that participating in the interview and talking about the topic of IDC care may cause distress to some people. If you do not wish to answer a question, you may skip it and go to the next question, or you may stop immediately. The NARI researchers are qualified and experienced in conducting interviews and will be able to provide you with support and information if you need it. If you become upset or distressed as a result of your participation in the research project, the facilitators will offer to stop the interview and advise you to seek medical support from your GP if you remain distressed. All care will be taken to maintain your privacy and confidentiality.

8 What if I withdraw from this research project?

If you do consent to participate, you may withdraw at any time. If you decide to withdraw from the project, please notify a member of the research team below.

If you decide to leave the research project, the researchers will not collect additional personal information from you. You should be aware that data collected up to the time you withdraw will form part of the research project results. If you do not want your data to be included, you must tell the researchers when you withdraw from the research project. At your request, any identifying information that the researchers have about you will be destroyed.

9 Could this research project be stopped unexpectedly?

This research project is unlikely to be stopped unexpectedly but may be terminated, reduced in scope or otherwise influenced by changes in the Victorian Department of Health's priorities.

10 What happens when the research project ends?

The results of this study will be provided directly to participants who indicate they would like to see the research outcomes and provide a valid email or postal address to researchers.

Part 2 How is the research project being conducted?

11 What will happen to information about me?

By providing verbal or written consent you consent to the research team collecting and using personal information about you for the research project. Any information obtained in connection with this research project that can identify you will remain confidential and securely stored as identifiable and re-identifiable data. Hard copy data will be stored in a locked filing cabinet and computer files will be password protected. Only members of the research team will have access to this data. You should note that these measures are only able to guarantee confidentiality within the limits of the law. All data collected in this project will be kept for seven years following completion of the study, and then be destroyed. Your information will only be used for the purpose of this research project and it will only be disclosed with your permission, except as required by law. You will not be identified in any publication, or data that results from this research project. Your confidentiality will be protected as we will report group data only. When using quotes from interviews only your age, gender and role) will be recorded. The Victorian Department of Health will receive regular anonymised reports about the research project and at the conclusion. The researchers will also publish the anonymised findings in peer review journals and at scientific conferences that target the continence and aged care workforce.

In accordance with relevant Australian and Victorian privacy and other relevant laws, you have the right to request access to the information about you that is collected and stored by the research team. You also have the right to request that any information with which you disagree be corrected. Please inform the research team member named at the end of this document if you would like to access your information.

12 Who is organising and funding the research?

This research project is being funded by the Victorian Department of Health.

No member of the research team will receive a personal financial benefit from your involvement in this research project (other than their ordinary wages).

13 Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC).

The Bellberry Human Research Ethics Committee has reviewed and approved this study in accordance with the National Statement on Ethical Conduct in Human Research (2007) – incorporating all updates. This Statement has been developed to protect the interests of people who agree to participate in human research studies. Should you wish to discuss the study or view a copy of the Complaint procedure with someone not directly involved, particularly in relation to matters concerning policies, information or complaints about the conduct of the study or your rights as a participant, you may contact the Operations Manager, Bellberry Limited on 08 8361 3222.

14 Further information and who to contact

The person you may need to contact will depend on the nature of your query. If you want any further information concerning this project or if you have any problems which may be related to

your involvement in the project, you can contact the responsible researcher on 0414 975 440 or any of the following people:

Research contact person

Name	<i>Dr Joan Ostaszkiewicz</i>
Position	<i>Director Aged Care Division, NARI</i>
Telephone	<i>0414 975 440</i>
Email	<i>j.ostaszkiewicz @nari.edu.au</i>

Name	<i>Ms Marie Vaughan</i>
Position	<i>Research Fellow, NARI</i>
Telephone	<i>0488 636 155</i>
Email	<i>m.vaughan@nari.edu.au</i>

Mailing Address	<i>NARI PO Box 2127 Royal Melbourne Hospital Victoria 3050 Australia</i>
-----------------	--

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

Reviewing HREC approving this research and HREC Executive Officer details

Reviewing HREC name	<i>Bellberry Limited</i>
HREC Executive Officer	<i>Operations Manager</i>
Telephone	<i>08 8361 3222</i>
Email	<i>bellberry@bellberry.com.au</i>

Consent Form - Adult providing own consent

Title *A consultation about catheter care and associated complications for older people in Victorian residential aged care homes*

Protocol Number *Bellberry 2023-01-027*

Project Sponsor *Victorian Department of Health*

Principal Investigator *Dr Joan Ostaszkiwicz*

Associate Investigators *Prof Briony Dow
A Prof Frances Batchelor
Dr Andrew Gilbert
Ms Marie Vaughan
Ms Caitlin Tay*

Location *National Ageing Research Institute*

Declaration by Participant

I have read the Participant Information Sheet or someone has read it to me in a language that I understand.

I understand the purposes, procedures and risks of the research described in the project.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project.

I understand that I will be given a signed copy of this document to keep.

☐

Verbal Consent provided

Name of Participant (please print) _____

Signature _____ Date _____

Declaration by Researcher[†]

I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Name of Researcher[†] (please print) _____

Signature _____ Date _____

[†] An appropriately qualified member of the research team must provide the explanation of, and information concerning, the research project.

Note: All parties signing the consent section must date their own signature

Form for Withdrawal of Participation - *Adult providing own consent*

Title *A consultation about catheter care and associated complications for older people in Victorian residential aged care homes*

Protocol Number *Bellberry 2023-01-027*

Project Sponsor *Victorian Department of Health*

Principal Investigator *Dr Joan Ostaszkievicz*

Associate Investigators *Prof Briony Dow
A Prof Frances Batchelor
Dr Andrew Gilbert
Ms Marie Vaughan
Ms Caitlin Tay*

Location *National Ageing Research Institute*

Declaration by Participant

I wish to withdraw from participation in the above research project and understand that such withdrawal will not affect my rights or care.

Name of Participant (please print) _____

Signature _____ Date _____

In the event that the participant's decision to withdraw is communicated verbally, the Senior Researcher must provide a description of the circumstances below.

Declaration by Researcher[†]

I have given a verbal explanation of the implications of withdrawal from the research project and I believe that the participant has understood that explanation.

Name of Researcher (please print) _____

Signature _____ Date _____

[†] An appropriately qualified member of the research team must provide information concerning withdrawal from the research project.

Note: All parties signing the consent section must date their own signature.

Appendix 12. Participant Information and Consent Form: Staff Interviews

Participant Information Sheet/Consent Form for Staff Interviews

Health/Social Science Research - *Adult providing own consent*

National Ageing Research Institute

Title	<i>A consultation about catheter care and associated complications in Victorian residential aged care homes</i>
Protocol Number	<i>Bellberry 2023-01-027</i>
Project Sponsor	<i>Victorian Department of Health</i>
Principal Investigators	<i>Dr Joan Ostaszkiewicz</i>
Associate Investigators	<i>Prof Briony Dow A Prof Frances Batchelor Dr Andrew Gilbert Ms Marie Vaughan Ms Caitlin Tay</i>
Location	<i>National Ageing Research Institute</i>

Part 1 What does my participation involve?

1 Introduction

Thank you for your interest in participating in this National Ageing Research Institute (NARI) research project, “A consultation *about catheter care and* associated complications in Victorian residential aged care homes”. You have been invited because you are a staff member working in a Victorian residential aged care facility with clinical experience in caring for a resident with an in-dwelling catheter (IDC)

This Participant Information Sheet/Consent Form tells you about the research project. It explains the processes involved with taking part. Knowing what is involved will help you decide if you want to take part in the research.

Please read this information carefully. Ask questions about anything that you don’t understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or local health worker.

Participation in this research is voluntary. If you don’t wish to take part, you don’t have to.

If you decide you want to take part in the research project, you will be asked to provide verbal consent prior to the interview commencing. Alternatively, you may sign the attached consent form and provide it to the research team in person or via email or mail (see contact details on Pg 5). Please keep a copy for yourself if desired.

By providing verbal or written consent you are telling us that you:

- Understand what you have read
- Consent to take part in the research project
- Consent to be involved in the research described
- Consent to the use of your personal and health information as described.

Please keep this Participant Information and Consent Form.

2 What is the purpose of this research?

Your ideas and input will be used by the National Ageing Research Institute (NARI) to develop a report for the Department of Health that will represent the views of the different stakeholder groups and will include specific and targeted recommendations to address the care needs of aged care residents with an in-dwelling catheter (IDC) in Victorian residential aged care homes.

3 What does participation in this research involve?

Should you agree to participate you will be invited to participate in a face-to-face interview with a researcher, lasting approximately 30-60 minutes.

If you agree, the interview will be audio-taped. Written records will also be taken, in addition to the audio-recording. The purpose of the audio and written notes is to assist the researchers (at the conclusion of the interview) to examine the issues that were raised. The information provided will not in any way be used to identify individuals, and only members of the research team will have access to the recordings. This research project has been designed to make sure the researchers interpret the results in a fair and appropriate way.

During the interview you will be asked about:

- Demographic information (age, gender etc.)
- You reason for participating
- You will be invited to share your experiences of providing support to a person with an IDC, your perceptions of challenges for residents and staff, staff roles, responsibilities and capabilities related to IDC care, and the structures and processes required to minimise and manage IDC-related complications.

There are no right or wrong answers to the questions that will be asked. The researchers are just interested in your opinions and perspectives.

There are no costs associated with participating in this research project. You will receive a \$40 gift card in recognition of your time.

5 Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. This can be done by contacting one of the researchers listed below.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your employment status.

6 What are the possible benefits of taking part?

There will be no direct benefit to you from your participation in this research; however, by participating in the project you have the ability to influence a final report and target recommendations to address the care needs of aged care residents with an IDC in Victorian residential aged care. This report will be provided to the Victorian Department of Health.

7 What are the possible risks and disadvantages of taking part?

It is possible that participating in the interview and talking about the topic of IDC care may cause distress to some people. If you do not wish to answer a question, you may skip it and go to the next question, or you may stop immediately. The NARI researchers are qualified and experienced in conducting interviews and will be able to provide you with support and information if you need it. If you become upset or distressed as a result of your participation in the research project, the facilitators will offer to stop the interview and advise you to seek medical support from your GP if you remain distressed. All care will be taken to maintain your privacy and confidentiality.

8 What if I withdraw from this research project?

If you do consent to participate, you may withdraw at any time. If you decide to withdraw from the project, please notify a member of the research team below.

If you decide to leave the research project, the researchers will not collect additional personal information from you. You should be aware that data collected up to the time you withdraw will form part of the research project results. If you do not want your data to be included, you must tell the researchers when you withdraw from the research project. At your request, any identifying information that the researchers have about you will be destroyed.

9 Could this research project be stopped unexpectedly?

This research project is unlikely to be stopped unexpectedly but may be terminated, reduced in scope or otherwise influenced by changes in the Victorian Department of Health's priorities.

10 What happens when the research project ends?

The results of this study will be provided directly to participants who indicate they would like to see the research outcomes and provide a valid email or postal address to researchers.

Part 2 How is the research project being conducted?

11 What will happen to information about me?

By providing verbal or written consent you consent to the research team collecting and using personal information about you for the research project. Any information obtained in connection with this research project that can identify you will remain confidential and securely stored as identifiable and re-identifiable data. Hard copy data will be stored in a locked filing cabinet and computer files will be password protected. Only members of the research team will have access to this data. You should note that these measures are only able to guarantee confidentiality within the limits of the law. All data collected in this project will be kept for seven years following completion of the study, and then be destroyed. Your information will only be used for the purpose of this research project and it will only be disclosed with your permission, except as required by law. You will not be identified in any publication, or data that results from this research project. Your confidentiality will be protected as we will report group data only. When using quotes from interviews only your age, gender and role) will be recorded. The Victorian Department of Health will receive regular anonymised reports about the research project and at the conclusion. The researchers will also publish the anonymised findings in peer review journals and at scientific conferences that target the continence and aged care workforce.

In accordance with relevant Australian and Victorian privacy and other relevant laws, you have the right to request access to the information about you that is collected and stored by the research team. You also have the right to request that any information with which you disagree be corrected. Please inform the research team member named at the end of this document if you would like to access your information.

12 Who is organising and funding the research?

This research project is being funded by the Victorian Department of Health.

No member of the research team will receive a personal financial benefit from your involvement in this research project (other than their ordinary wages).

13 Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC).

The Bellberry Human Research Ethics Committee has reviewed and approved this study in accordance with the National Statement on Ethical Conduct in Human Research (2007) – incorporating all updates. This Statement has been developed to protect the interests of people who agree to participate in human research studies. Should you wish to discuss the study or view a copy of the Complaint procedure with someone not directly involved, particularly in relation to matters concerning policies, information or complaints about the conduct of the study or your rights as a participant, you may contact the Operations Manager, Bellberry Limited on 08 8361 3222.

14 Further information and who to contact

The person you may need to contact will depend on the nature of your query. If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact the responsible researcher on 0414 975 440 or any of the following people:

Research contact person

Name	<i>Dr Joan Ostaszkiewicz</i>
Position	<i>Director Aged Care Division, NARI</i>
Telephone	<i>0414 975 440</i>
Email	<i>j.ostaszkiewicz @nari.edu.au</i>

Name	<i>Ms Isabella Hall</i>
Position	<i>Research Assistant, NARI</i>
Telephone	<i>0434 554 148</i>
Email	<i>i.hall@nari.edu.au</i>

Mailing Address	<i>NARI PO Box 2127 Royal Melbourne Hospital Victoria 3050 Australia</i>
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If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

Reviewing HREC approving this research and HREC Executive Officer details

Reviewing HREC name	<i>Bellberry Limited</i>
HREC Executive Officer	<i>Operations Manager</i>
Telephone	<i>08 8361 3222</i>
Email	<i>bellberry@bellberry.com.au</i>

Consent Form - Adult providing own consent

Title *A consultation about catheter care and associated complications in Victorian residential aged care homes*

Protocol Number *Bellberry 2023-01-027*

Project Sponsor *Victorian Department of Health*

Principal Investigator *Dr Joan Ostaszkievicz*

Associate Investigators *Prof Briony Dow
A Prof Frances Batchelor
Dr Andrew Gilbert
Ms Marie Vaughan
Ms Caitlin Tay*

Location *National Ageing Research Institute*

Declaration by Participant

I have read the Participant Information Sheet or someone has read it to me in a language that I understand.

I understand the purposes, procedures and risks of the research described in the project.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project.

I understand that I will be given a signed copy of this document to keep.

☐

Verbal Consent provided

Name of Participant (please print) _____

Signature _____ Date _____

Declaration by Researcher[†]

I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Name of Researcher[†] (please print) _____

Signature _____ Date _____

[†] An appropriately qualified member of the research team must provide the explanation of, and information concerning, the research project.

Note: All parties signing the consent section must date their own signature

Form for Withdrawal of Participation - *Adult providing own consent*

Title *A consultation about catheter care and associated complications in Victorian residential aged care homes*

Protocol Number *Bellberry 2023-01-027*

Project Sponsor *Victorian Department of Health*

Principal Investigator *Dr Joan Ostaszkievicz*

Associate Investigators *Prof Briony Dow
A Prof Frances Batchelor
Dr Andrew Gilbert
Ms Marie Vaughan
Ms Caitlin Tay*

Location *National Ageing Research Institute*

Declaration by Participant

I wish to withdraw from participation in the above research project and understand that such withdrawal will not affect my employment, or my relationships with the researchers or the National Ageing Research Institute

Name of Participant (please print) _____

Signature _____ Date _____

In the event that the participant's decision to withdraw is communicated verbally, the Senior Researcher must provide a description of the circumstances below.

Declaration by Researcher[†]

I have given a verbal explanation of the implications of withdrawal from the research project and I believe that the participant has understood that explanation.

Name of Researcher (please print) _____

Signature _____ Date _____

[†] An appropriately qualified member of the research team must provide information concerning withdrawal from the research project.

Note: All parties signing the consent section must date their own signature

Appendix 13. Focus Group Schedule for Residential-in-Reach Service Staff

Section 1: Demographic information (personal)

Question 1: What is your current role in the RIR service?

- Medical practitioner
 - Geriatrician
 - Advanced Trainee
 - Registrar
 - Resident
 - Palliative Care Consultant
 - GP
- Nurse
 - NUM/Team Leader
 - Nurse Practitioner
 - Clinical Nurse Consultant
 - Registered Nurse Grade 3 or 4
 - Endorsed Enrolled Nurse
- Allied Health (please specify)
- Other (please specify).....

Question 2: How long have you worked in your current role?

- 0-2 years
- 2-4 years
- 4 or more years

Section 2: Focus group prompts

Prompt 1: Experiences of consulting to Victorian residential aged care homes about IDC care

Prompt 2: The main reasons for referrals related to IDCs

Prompt 3: Perceived challenges for aged care residents with an IDC (if any)

Prompt 4: Perceived gender differences in aged care residents' experiences of having an IDC (if any)

Prompt 5: Perceived challenges for RAC staff when caring for residents with an IDC (if any)

Prompt 6: Understanding of the roles and responsibilities of different RAC staff members in caring for residents with an IDC

Prompt 7: Perceived capabilities of RIRS and RAC staff to prevent and manage complications associated with IDCs in Victorian RACs

Prompt 8: Structures and processes required to minimise and manage complications associated with IDCs in Victorian RACs (If any)

Prompt 9: Other strategies required to improve catheter care in Victorian RACs (If any)

Prompt 10: Educational resources available about IDC care

Appendix 14. Survey for RACF Managers

Facility Characteristics

Would you describe your facility as:

- ☐ Metropolitan
☐ Regional
☐ Rural

Would you describe your facility as a:

- ☐ Not-for-profit provider
☐ Private provider (for profit)
☐ Public Sector Residential Aged Care service
☐ Multi-Purpose Service
☐ Other (please indicate)

Other (please indicate):

How many residents are living in your facility right now?

Would you describe your role within your organisation as:

- ☐ Regional manager (responsible for more than one RAC)
☐ Facility manager
☐ Clinical practice manager/clinical care coordinator
☐ Senior Nurse/Unit Manager
☐ Other management or senior clinical position (please specify)
☐ Non-management (please specify)

Other management or senior clinical position (please specify):

Non-management (please specify):

What is the total FTE for RNs working in your facility?
 (1.0 FTE = 1 full time staff member)

What is the total FTE for ENs working in your facility?
 (1.0 FTE = 1 full time staff member)

Clinical Governance and Resources

Does your organisation have a policy regarding continence care?

- ☐ Yes
☐ No
☐ Don't know
☐ Prefer not to say

Does your organisation have a policy or protocol that allows RNs / ENs to catheterise females?

- ☐ Yes
☐ No
☐ Don't Know
☐ Prefer not to say

Does your organisation have a policy or protocol that allows RNs / ENs to catheterise males?

- ☐ Yes
☐ No
☐ Don't know
☐ Prefer not to say

Does your facility have a policy or protocol about the need to review the appropriateness of the IDC?

- ☐ Yes
☐ No
☐ Don't know
☐ Prefer not to say

What equipment do you have onsite to optimise best practice care to residents with an IDC? Please select all that apply.

- ☐ Bladder scanner
☐ Replacement catheters appropriate to individual resident needs
☐ Overnight drainage bags
☐ Daytime leg bags
☐ Sterile catheter packs
☐ Catheter anchoring/securing devices
☐ Sterile gloves
☐ Lubricant
☐ Anaesthetic gel
☐ Other (please describe)

Other (please describe) :

Please indicate which (if any) of the following health professionals are employed by your facility who are qualified to catheterize residents? Please select all that apply.

- ☐ Enrolled Nurse
☐ Registered Nurse
☐ Nurse Practitioner
☐ Continence Nurse Specialist
☐ General Practitioner
☐ Medical Specialist (Please specify)
☐ Other (Please specify)

Medical specialist (please specify) :

Other (please specify) :

Which health professionals undertake catheterisation for resident's in your care? Please select all that apply.

- ☐ Registered Nurse employed by your residential aged care provider (including agency)
- ☐ Enrolled Nurse employed by your residential aged care provider (including agency)
- ☐ General Practitioner
- ☐ Private Urologist
- ☐ Urology outpatient department
- ☐ Visiting hospital staff
- ☐ Emergency Department
- ☐ Contracted service
- ☐ Residential InReach Service
- ☐ Other (please describe)

Other (please describe):

Indwelling Urinary Catheter (IDC) Prevalence

How many residents at your facility currently have an IDC?

Of the residents with an IDC, how many are male with a urethral catheter?

Of the residents with an IDC, how many are female with a urethral catheter?

Of the residents with an IDC, how many are male with a suprapubic catheter?

Of the residents with an IDC, how many are female with a suprapubic catheter?

Does every resident with an IDC have a documented reason for their IDC?

☐ Yes ☐ No ☐ Unsure

On average, how frequently do residents in your facility have these complications with an IDC?

	Never	Less than once a month	Once or twice a month	Once or twice a week	Several times a week
IDC-related blockage	☐	☐	☐	☐	☐
Leakage around the catheter	☐	☐	☐	☐	☐
Infection due to the catheter	☐	☐	☐	☐	☐
Unplanned/traumatic removal	☐	☐	☐	☐	☐
Haematuria	☐	☐	☐	☐	☐
IDC associated pain	☐	☐	☐	☐	☐
Admission to ED due to an IDC-related problem	☐	☐	☐	☐	☐
Other problems (please describe)	☐	☐	☐	☐	☐

Other problems (please describe) : _____

How often is IDC blockage resolved internally by your staff?

- ☐ Always
☐ Most of the time
☐ Sometimes
☐ Rarely
☐ Never

How often is bypassing around the catheter is resolved internally by your staff?

- ☐ Always
☐ Most of the time
☐ Sometimes
☐ Rarely
☐ Never

How often is infection due to the catheter resolved by the resident's GP or GP locum service alone?

- ☐ Always
☐ Most of the time
☐ Sometimes
☐ Rarely
☐ Never

How often are unplanned removals of IDCs resolved internally by your staff?

- ☐ Always
☐ Most of the time
☐ Sometimes
☐ Rarely
☐ Never

How often is haematuria in residents with IDCs resolved without referral to external services?

- ☐ Always
☐ Most of the time
☐ Sometimes
☐ Rarely
☐ Never

How often is IDC-related pain referred to an external service?

- ☐ Always
☐ Most of the time
☐ Sometimes
☐ Rarely
☐ Never

In the last 3 months, approximately how many referrals has your facility made to the Victorian Residential In-Reach Service for IDC-related complications?

Of these, how many were resolved over the phone?

How many required an on-site visit/consultation from the RIRS?

How much do you agree with this statement?

"I am confident that staff in my facility have the knowledge, skills and capacity to care for residents with IDCs"

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree nor disagree
- ☐ Disagree
- ☐ Strongly disagree

Appendix 15. Plain Language Statement: RACF Manager Survey

Plain Language Statement (to appear at the introduction to the survey)

Introduction

The National Ageing Research Institute (NARI) would like to invite managers of Victorian residential aged care homes to participate in an important survey to discuss care for people living with an indwelling urinary catheter (IDC) in residential aged care homes and the barriers to receiving care.

What is the purpose of this research?

Your ideas and input will be used by NARI to develop a report for the Department of Health that will represent the views of the different stakeholder groups and will include specific and targeted recommendations to address the care needs of aged care residents with an IDC in Victorian residential aged care homes.

What does participation in this research involve?

The survey involves you completing <insert number> questions and will take approximately <insert number> minutes. You do not have to complete this survey if you don't want to. Your participation is completely voluntary. By completing the survey, you will go in the running to win one of three \$100 gift vouchers.

What are the possible benefits and risks?

There will be no direct benefit to you from your participation in this research; however, by participating in the project you have the ability to influence the quality of IDC Care in residential aged care facilities. We do not anticipate that participating in this survey will cause you any harm; if you do not wish to answer a question, you may skip it and go to the next question, or you may stop immediately. Due to the confidential nature of your participation you will not be able to withdraw your answers once submitted. The results of this study will be provided directly to participants who indicate they would like to see the research outcomes and provide a valid email or postal address.

What will happen to the information I provide?

Consent for participation in the survey will be implied upon its completion and submission. By completing the survey, you agree to the collection and use of the information for research conducted at NARI. If you choose to withdraw partway through the survey, any responses you submit will be retained. The information will be used to generally inform an IDC in Victorian residential aged care homes report that will be provided to the Victorian Department of Health. Your answers will be treated confidentially and you will not be identified in any way. Any information that could be used to identify you (your email address if you choose to provide it, and your IP address) will be stored securely on a password protected server accessible only by the research team. Data will be exported from Redcap and directly stored on password protected computer systems at the National Ageing Research Institute (NARI). Data will only be accessible by the research team and will be managed by the responsible researcher. All data collected in this project will be kept for seven years following completion of the study, and then be destroyed. Your information will only be used for the purpose of this research project and it will only be disclosed with your permission, except as required by law. Your confidentiality will be protected as we will report group data only. You will not be identified in any publication, or data that results from this research project. If you wish to withdraw any identifying information (such as your email address, if provided) please contact a member of the research team.

The Victorian Department of Health will receive regular anonymised reports about the research project and at the conclusion. The researchers will also publish the anonymised findings in peer review journals and at scientific conferences that target the aged care workforce.

Who is organising and funding the research?

The research is being conducted by the National Ageing Research Institute and is funded by the Victorian Department of Health. No member of the research team will receive a personal financial benefit from your involvement in this research project (other than their ordinary wages).

Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC).

The Bellberry Human Research Ethics Committee has reviewed and approved this study in accordance with the National Statement on Ethical Conduct in Human Research (2007) – incorporating all updates. This Statement has been developed to protect the interests of people who agree to participate in human research studies. Should you wish to discuss the study or view a copy of the Complaint procedure with someone not directly involved, particularly in relation to matters concerning policies, information or complaints about the conduct of the study or your rights as a participant, you may contact the Operations Manager, Bellberry Limited on 08 8361 3222.

Further information and who to contact

If you would like more information about this survey or the project please feel free to contact:

Dr Joan Ostaszkiewicz, Director Aged Care Division, NARI

Telephone: 0414 975 440

Email: j.ostaszkiewicz@nari.edu.au

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

Bellberry Limited: Operations Manager

Telephone: 08 8361 3222

Email: bellberry@bellberry.com.au

We greatly value your input into this project and appreciate the time you are taking to complete the survey.

Do you agree to participate in this study?

- Yes
- No

Appendix 16. Interview Schedule for RACF Staff

Section 1: Demographic information (personal)

Question 1: Are you of Aboriginal and/or Torres Strait Islander origin?

- Aboriginal
- Torres Strait Islander
- Both Aboriginal and Torres Strait Islander
- No
- Prefer not to answer
- Don't know

Question 2: Are you from a Culturally or Linguistically Diverse (CALD) background?

- Yes
- No
- Prefer not to answer

Question 3: Would you describe your employment as;

- Permanent Full-time
- Permanent Part-time
- Casual/Contractor
- Agency or sub-contractor staff – Full time
- Agency or sub-contractor staff – Part time

Question 4: How would you describe your occupation type?

- Nurse
 - Nurse Practitioner
 - Clinical Nurse Consultant
 - Registered Nurse
 - Enrolled Nurse
- Personal Care Assistant
 - PCA
 - PCA (formal traineeship)
- Allied Health
 - Occupational Therapist
 - Physiotherapist
 - Dietitian
 - Exercise Physiologist
 - Speech Therapist
 - Diversional Therapist
 - Lifestyle co-ordinator
 - Aboriginal and Torres Strait Islander Health Worker/Practitioner
 - Podiatrist
 - Psychologist
 - Pharmacist
 - Social Worker
 - Allied Health - other

- Allied Health Assistant

Question 5: How long have you worked in aged care?

- 0-5 years
- 5-10 years
- 10-20 years
- 20+ years

Question 6: How long have you worked in your current role?

- 0-5 years
- 5-10 years
- 10-20 years
- 20+ years

Question 7: On a scale of 1-10, how confident are you have the knowledge and skills to care for residents with IDCs? _____

Section 2: Interview prompts

Prompt 1: Challenges experienced when caring for residents with an IDC (if any)

Prompt 2: Perceived challenges for aged care residents with an IDC (if any)

Prompt 3: Roles and responsibilities of different staff members in caring for residents with an IDC

Prompt 4: Staff competence to prevent and manage complications associated with IDCs

Prompt 5: Structures and processes required to minimise and manage complications associated with IDCs (if any)

Prompt 6: The effectiveness of these structures and processes

Prompt 7: Strategies to improve IDC care in Victorian residential aged care homes (If any)

Prompt 8: Internal or external supports/resources to help care for residents with an IDC (if any)

Prompt 9: The effectiveness of these supports/resources

Prompt 10: Sources of evidence for guidance about IDC care (if any)

Prompt 11: How staff know whether they are meeting clinical standards for IDC care

Prompt 12: Understandings/knowledge about the medical indications for IDCs

Prompt 13: Understandings/knowledge of internal policies for reviewing the clinical appropriateness of IDCs

Appendix 17. Interview Schedule for RACF Residents

RAC Residents with IDC

Section 1: Demographic information (personal)

Question 1: What is your gender?

- ☐ Woman
- ☐ Man
- ☐ Self-described (please specify): _____
- ☐ Prefer not to answer

Question 2: What is your age? (optional) _____

Question 3: How long have you had a catheter? _____

Question 4: Do you know the medical reason you have a catheter?

- ☐ For urinary retention/obstruction
- ☐ For hospice/comfort care/palliative care
- ☐ To measure urinary output
- ☐ To support immobilization for trauma or surgery
- ☐ To facilitate healing of severe perineal and sacral wounds in residents with incontinence
- ☐ A neurologic condition that affects bladder function
- ☐ Other
- ☐ Unknown

Section 2: Interview prompts

Prompt 1: The background to having a catheter inserted

Possible follow up prompts:

- a) How long they have had the catheter
- b) How long they need to have the catheter
- c) Who looks after the catheter

Prompt 2: The experience of having a catheter

Possible follow up prompts:

- a) Negative experiences
- b) Positive experiences

Prompt 3: Concerns about having a catheter

Possible follow up prompts:

- a) Experience of blockage

- b) Experience of leakage
- c) Experience of infection
- d) How it makes them feel
- e) Need to be admitted to hospital

Prompt 4: Experience of how these problems were managed

Prompt 5: Satisfaction with help needed for catheter

Prompt 6: Advice/information received about maintaining their health and wellbeing with a catheter

Prompt 7: Self-management strategies the resident adopts to maintain their health and wellbeing with a catheter

Prompt 8: Suggestions for how catheter care in residential aged care homes can be improved

Prompt 9. Knowledge of how often the need for the catheter is reviewed

RAC Residents with recently removed IDC

Section 1: Demographic information (personal)

Question 1: What is your gender?

- ☐ Woman
- ☐ Man
- ☐ Self-described (please specify): _____
- ☐ Prefer not to answer

Question 2: What is your age? (optional) _____

Question 3: How long did you have a catheter? _____

Question 4: When was the catheter removed? _____

Question 5: Do you know the medical reason you had a catheter?

- ☐ For urinary retention/obstruction
- ☐ For hospice/comfort care/palliative care
- ☐ To measure urinary output
- ☐ To support immobilisation for trauma or surgery
- ☐ To facilitate healing of severe perineal and sacral wounds in residents with incontinence
- ☐ For a neurologic condition that affects bladder function
- ☐ Other
- ☐ Unknown

Section 2: Interview prompts

Prompt 1: The background to having a catheter inserted

Possible follow up prompts:

- d) How long they have had the catheter
- e) How long they need to have the catheter
- f) Who looks after the catheter

Prompt 2: The experience of having a catheter

Possible follow up prompts:

- c) Negative experiences
- d) Positive experiences

Prompt 3: Concerns about having a catheter

Possible follow up prompts:

- f) Experience of blockage

- g) Experience of leakage
- h) Experience of infection
- i) How it makes them feel
- j) Need to be admitted to hospital

Prompt 4: Experience of how these problems were managed

Prompt 5: Satisfaction with help with catheter

Prompt 6: Advice/information received about maintaining health and wellbeing with a catheter

Prompt 7: Self-management strategies adopted to maintain your health and wellbeing with a catheter

Prompt 8: Suggestions for how catheter care in residential aged care homes can be improved

Prompt 9: Knowledge of how often the need for the catheter is reviewed

Schedule for proxies of residents with an IDC

Section 1: Demographic information (personal)

Question 1: What is your relationship to (x)?

- ☐ Spousal partner
- ☐ Son
- ☐ Daughter
- ☐ Grandchild
- ☐ Friend
- ☐ Other.....

Question 2: How long has (x) had a catheter?

Question 3: Do you know the medical reason (x) has a catheter?

- ☐ For urinary retention/obstruction
- ☐ For hospice/comfort care/palliative care
- ☐ To measure urinary output
- ☐ To support immobilisation for trauma or surgery
- ☐ To facilitate healing of severe perineal and sacral wounds in residents with incontinence
- ☐ For a neurologic condition that affects bladder function
- ☐ Other
- ☐ Unknown

Section 2: Interview prompts

Prompt 1: Satisfaction with the care that (x) receives to prevent and manage complications associated with having a catheter

Prompt 2: Perceived barriers to good catheter care for (x) (if any)

Prompt 3: Concerns about (x's) catheter

Possible follow up questions:

- Experience of blockage
- Experience of leakage
- Experience of infection
- How it makes them feel
- Need to be admitted to hospital

Prompt 4: Experience of how these problems were managed

Prompt 5: Suggestions for how (x's) catheter care can be improved (if any)

Schedule for proxies of residents with a recently removed IDC

Section 1: Demographic information (personal)

Question 1: What is your relationship to (x)?

- ☐ Spousal partner
- ☐ Son
- ☐ Daughter
- ☐ Grandchild
- ☐ Friend
- ☐ Other.....

Question 2: How long did (x) have a catheter?

Question 3: Do you know the medical reason (x) had a catheter?

- ☐ For urinary retention/obstruction
- ☐ For hospice/comfort care/palliative care
- ☐ To measure urinary output
- ☐ To support immobilization for trauma or surgery
- ☐ To facilitate healing of severe perineal and sacral wounds in residents with incontinence
- ☐ Other
- ☐ Unknown

Section 2: Interview prompts

Prompt 1: Satisfaction with the care that (x) received to prevent and manage complications associated with having a catheter

Prompt 2: Perceived barriers to good catheter care for (x) (if any)

Prompt 3: Concerns about (x's) catheter

Possible follow up questions:

- Experience of catheter being removed
- Experience of blockage
- Experience of leakage
- Experience of infection
- How it makes them feel
- Need to be admitted to hospital

Prompt 4: Experience of how these problems were managed

Prompt 5: Suggestions for how (x's) catheter care could have been improved (if any)

Appendix 18. Communication: RACF Resident Interviews

Dear <insert name>

Thank you for your interest in this consultation which seeks to better understand your concerns associated with indwelling catheters in your place of care. This project is funded by the Victorian Department of Health.

We invite you to participate in a confidential interview to share your experiences and expectations about the care you receive. Specifically, we would like to hear from you about:

- Your experiences of living with a catheter
- Impact of it on your life
- Challenges you may experience with your catheter
- Any complications you experience and how you manage them
- Your satisfaction with the care you receive

As you have chosen an online interview, the meeting will be held via Microsoft Teams, and will be approximately 30-60 minutes. **Please reply to this email to confirm your interview and provide us with your available dates and times (Thursdays and Fridays, 9:00am – 5:00pm). If you're not available on these days, please inform us and we will arrange a time that suits you. Alternatively, please provide with your phone number if you would like us to call you to arrange an interview time and place.**

There are no right or wrong answers to the questions that will be asked. We are just interested in your opinions and perspectives.

There are no costs associated with participating in this research project. You will receive a \$40 gift card in recognition of your time.

Detailed information about the research is included in the attached document. You are welcome to share and discuss this with a relative, friend or local health worker. Please note, your participation is completely voluntary, and your decision about whether to take part or not, will not affect your residential rights or care.

For more details about the project and questions, please contact Caitlin Tay at c.tay@nari.edu.au.

Thanks again for your interest in this project and we look forward to hearing from you.

Kind regards,

Caitlin Tay

National Ageing Research Institute

Appendix 19. Communication: RACF Staff Interviews

Dear <insert name>

Thank you for your interest in this consultation which seeks to better understand the clinical risks associated with indwelling catheters in Victorian residential aged care homes. It is funded by the Victorian Department of Health.

We invite you to participate in a confidential interview and look forward to hearing from you about:

- Your experiences of providing support to a person with an indwelling catheter
- Your perceptions of challenges for residents and staff
- Staff roles, responsibilities and capabilities related to catheter care
- The structures and processes required to minimise and manage catheter-related complications.

As you have chosen an online interview, the meeting will be held via Microsoft Teams, and will be approximately 30-60 minutes. **Please reply to this email to confirm your interview and provide us with your available dates and times (Thursdays and Fridays, 9:00am – 5:00pm). If you're not available on these days, please inform us and we will arrange a time that suits you.**

There are no right or wrong answers to the questions that will be asked. We are just interested in your opinions and perspectives.

There are no costs associated with participating in this research project. You will receive a \$40 gift card in recognition of your time.

Detailed information about the research is included in the attached document. Please note, your participation is completely voluntary, and your decision about whether to take part or not, will not affect your employment status.

For more details about the project and questions, please contact Caitlin Tay at c.tay@nari.edu.au.

Thanks again for your interest in this project and we look forward to hearing from you.

Kind regards,

Caitlin Tay

National Ageing Research Institute

Appendix 20. Bellberry Ethics Approval



03-May-23

Professor Joan Ostaszkiewicz
National Ageing Research Institute
34-54 Poplar Rd
Parkville Vic 3152

Dear Professor Ostaszkiewicz,

Re: Application No: 2023-01-027

Study Title: A consultation to inform a targeted response to catheter-associated complications in Victorian residential aged care homes [2023-01-027]

Application Type: NEW

Type of Review: FULLBOARD

Name of the Documents Submitted & Approved: Attachments

Recruitment flyer focus group 2013-01-027 V2
Recruitment flyer interview residents 2013-01-027
Recruitment flyer interview staff 2013-01-027
Recruitment flyer survey 2013-01-027
Recruitment_Letter of invitation_interview_staff 2023-01-027 V2(Clean version)
Recruitment_Letter of invitation_survey 2023-01-027 V2 (Clean version)
Recruitment_Letter of invitation_interview_residents 2023-01-027 V2 (Clean version)
Recruitment_Letter of invitation_focus group 2023-01-027 V2 (Clean version)
Social Media Plan 2023-01-027
Question guide_focus groups 2023-01-027 V2 (Clean version)
Question guide_interviews_residents_staff 2023-01-027 V2 (Clean version)
Question guide_manager_survey 2023-01-027 V2 (Clean version)
Question guide_resident_staff_survey 2023-01-027
PICF focus group 2023-01-027 V2_(Clean version)
PICF resident interviews 2023-01-027 V2_(Clean version)
PICF staff interviews 2023-01-027 V2_(Clean version)
Plain Language Statement manager survey 2023-01-027 V2(CV)
Plain Language Statement resident survey 2023-01-027
Plain Language Statement staff_survey 2023-01-027
Project Protocol DHVIC IDC consultation 2023-01-027_V2(Clean version)

Includes:

Receipt of the following documents has been noted:

Joan Ostaszkiewicz CV

2023-01-027 (J Ostaszkiewicz) Fully executed HREC Indemnity

Date of Meeting: 22-Mar-23

123 Glen Osmond Road Eastwood South Australia 5063
P 08 8361 3222 E bellberry@bellberry.com.au www.bellberry.com.au
ABN 16 109 019 730

Date of Approval: 03-May-23

Period of Approval: 03-May-23 - 03-May-24

Thank you for submitting the above-mentioned application.

I wish to advise that the Bellberry Human Research Ethics Committee has approved this project and that the application meets the requirements of the National Statement subject to the conditions mentioned below. For clarity, the 'Date of Meeting' is a system-generated field. Please only take note of the 'Date of Approval' and 'Period of Approval' as relevant.

CONDITIONS:-

- **This letter constitutes ethical and scientific approval only. You must not commence the research project at any site until your Research Governance Office/ Institution/Organisational delegate has granted their approval. Sites are responsible for ensuring there are executed indemnities, contracts, and appropriate insurance in place before the commencement of the study at the site. Sites are also responsible for ensuring their site-specific documents are based on the current Master approved documentation.**
- All changes to the approved study documentation must be submitted to Bellberry via an Amendment Form for review and approval prior to implementation.
- Safety reporting and Serious Breaches should be reported to the Bellberry Human Research Ethics Committee as per the monitoring guidelines posted on the website www.bellberry.com.au
- A progress report must be completed annually for the duration of the trial. The due date for all additional sites will fall in line with the lead sites original approval date. Submission of the progress report is to be within 30 days before the due date. Requests for an annual extension will be granted upon successful completion and noting of a progress report.
- A final report is due on completion of all closeout activities (clinical trials) or final reconciliation of study activities (non-clinical trials) The site must also provide a copy of the Sponsor's final report where there are study outcomes that the HREC should be aware of such as issues related to participant safety
- The Principal Investigator must inform the HREC, by way of an amendment, of the outcomes of any audit by a regulator or organisation/body.
- The data collected for the purpose of this research project cannot be used for any other purpose without the approval of a Human Research Ethics Committee. Requests to use this data for other purposes must be made in the form of a formal research proposal
- All research data, including electronic data is to be stored by the Principal Investigator for 15 years after the research has been completed or after the last contact, whichever is the later. Data must be recorded in a durable and appropriately referenced form and comply with relevant privacy protocols.
- Copies of all Master/Site specific documentation and any other data used in this research may be inspected at any time by representatives of the Bellberry Human Research Ethics Committee. This may be in the form of a Bellberry site monitoring visit or requested electronically via a desktop audit.
- Bellberry Human Research Ethics Committee approval is conditional upon your meeting any statutory and licensing obligations; data custodian or other organisational authorisations that you may have with this project.

Details of Ethics Committee:

The Bellberry Human Research Ethics Committee (HREC) reviewed this study in accordance with the National Health and Medical Research Council's National Statement on Ethical Conduct in Human Research (2007, incorporating all updates) on the above meeting date. Bellberry Human Research Ethics Committees do not disclose personal details of its reviewing members. A member listing is available as an attachment in eProtocol. Please note that the Principal Investigator and Co-Investigators were not members of the Bellberry Human Research Ethics Committee that reviewed this study.

This study has been given the above reference number. Please remember to log on to eProtocol for all further correspondence with the Committee.

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ABN 16 109 019 730

Please do not hesitate to contact me if further clarification is required.

Yours sincerely



Brian Stoffell

Chair, Committee I

BELLBERRY HUMAN RESEARCH ETHICS COMMITTEE

Committee Name/NHMRC Codes: A/ EC00372; B/ EC00419; C/ EC00430; D/ EC00444;
E/ EC00450; F/ EC00455; G/ EC00458; H/ EC00459; I/ EC00468; J/ EC00469; K/ EC00470; L/ EC00471.

e-protocol

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Appendix 21. Project Timelines

Task	Time	Deliverables
Project establishment and oversight	Feb-Mar 2023	Final project design Staffing established First meeting with DoH
Ethics application	Feb – Mar 2023	Prepare and submit ethics application
Finalise interview sample	Mar-Apr 2023	Identify key stakeholders for recruitment
Finalise survey sample	Apr-May 2023	
Conduct interviews and focus group	May-Jun 2023	Conduct, record and analyse interviews and focus group Second meeting with DoH
Conduct survey	Jun – Jul 2023	
Transcription and coding	Jun – Jul 2023	Interviews transcribed and coded
Data synthesis and analysis	Jul –Aug 2023	Survey findings analysed and findings from both sources synthesized in a draft report
Final report	Sept 2023	Final report drafted and submitted to DoH Third meeting with DoH
Stakeholder information forum	Oct 2023	Present outcomes to key stakeholder groups