



Royal Commission
into Aged Care Quality and Safety

INSIDE THE SYSTEM: AGED CARE RESIDENTS' PERSPECTIVES

RESEARCH PAPER 13

OCTOBER 2020

The Royal Commission into Aged Care Quality and Safety was established by Letters Patent on 8 October 2018. Replacement Letters Patent were issued on 6 December 2018, and amended on 13 September 2019 and 25 June 2020.

The Honourable Tony Pagone QC and Ms Lynelle Briggs AO have been appointed as Royal Commissioners. They are required to provide a final report by 26 February 2021.

The Royal Commission releases consultation, research and background papers. This research paper has been prepared by the National Ageing Research Institute for the information of Commissioners and the public. The views expressed in this paper are not necessarily the views of the Commissioners.

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Inside the system: aged care residents' perspectives

Report for the Royal Commission into
Aged Care Quality and Safety

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This report has been prepared by the **National Ageing Research Institute (NARI)** for the information of the **Royal Commission into Aged Care Quality and Safety** ('the Royal Commission') and the public. The views expressed in this paper are not necessarily the views of the Commissioners.

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Glossary of Abbreviations and Terms

Abbreviation/term	Description
ANOVA	Analysis of variance
CAPI	Computer Assisted Personal Interviewing
CASP-12	Control, Autonomy, Self-Realisation and Pleasure scale
Carers	Family and informal carers
Care staff/care workers	Paid residential aged care workers
CCI-6D	Consumer Choice Index-6 Dimension questionnaire
CI	Confidence interval
GLS	General Life Satisfaction questionnaire
Ipsos	Ipsos Global Market Research
IQR	Interquartile range
IRR	Incidence rate ratio
NARI	National Ageing Research Institute
Proxy	Person completing survey on behalf of a resident
RACF/s	Residential aged care facility/ies
Representative	The nominated representative of a person receiving residential care service (i.e. resident)
Resident	Person receiving residential aged care services
RFQ	Resident Feedback Questionnaire
Royal Commission	Royal Commission into Aged Care Quality and Safety
SD	Standard deviation
SPRC	Social Policy Research Centre
UNSW	University of New South Wales

Executive summary

Background

The Royal Commission into Aged Care Quality and Safety's terms of reference include inquiring into the quality of aged care services provided to Australians, the extent to which those services meet the needs of the people accessing them, and the extent of substandard care being provided.

This report presents the results of a survey designed to enable those living in residential aged care, including those living with cognitive decline, to express how they feel about their lives and the care they receive. To our knowledge, this is the first detailed study of its kind in Australia.

The study was undertaken by the National Ageing Research Institute, in partnership with Ipsos and the Social Policy Research Centre of the University of New South Wales. The study complements a separate survey that was conducted to seek the views of older people that receive home care or respite care services, covered in a separate report¹.

Design

The survey included 391 residents or, where necessary, the resident's representative as a proxy. Residents were drawn randomly from a representative random sample of 67 Australian residential aged care facilities (RACFs). The survey approach removed or minimised aged care providers' influence on respondents and their responses.

Surveys were conducted from January to mid-March 2020 and halted early, prior to the lockdown of aged care facilities associated with the first wave of the COVID-19 pandemic. Consequently, the sample size is not as large as planned and the confidence intervals around the survey estimates are larger, though still reliable.

The survey comprised a number of questionnaires exploring quality of care, general life satisfaction, quality of life, and concerns and complaints. Data was weighted to account for the residential aged care population of Australia.

Quality of care

On a number of metrics, a significant share of residents indicated that some aspect of the quality of their care and services was failing them. Depending on one's perspective, this share is at least 33%. The responses to individual questions showed that problems exist across a broad range of areas.

In the Quality of Care questionnaire, almost 7% reported that they were 'sometimes', 'rarely' or 'never' treated with respect and dignity, while almost 13% said they only sometimes (or less often) received the support to make their own decisions about the care and services they receive. Nearly 16% said they only sometimes (or less often) receive care and support from appropriately skilled and trained staff, while almost 8% said they only sometimes (or less often) received the support and services they felt were important for their health and well-being. Almost 17% mainly felt unsupported in maintaining their social relationships and community connections. Between 18% and 23% of residents only sometimes (or less often) knew how to lodge a complaint, were comfortable lodging a complaint, and felt confident that appropriate action would be taken.

Results from the CCI-6D questionnaire, an instrument that measures quality of care across six domains, indicate that about 41% of residents were 'rarely' or only 'sometimes' satisfied with the amount of time staff spent with them. Inflexibility in staff care routines was noted by 44% of residents. When asked about the living space, 49% of residents 'rarely' or only 'sometimes' felt at home in the shared space of the facility and 36%

¹ Batchelor et al., 2020

'rarely' or only 'sometimes' felt at home in their own room. Nearly 12% could not access outside and gardens, and around 16% could only 'sometimes' gain access. About 57% felt that they were 'rarely' or only 'sometimes' offered things to do that made them feel valued.

Life satisfaction and quality

Aged care quality affects residents' life satisfaction and their quality of life². Despite the problems with aged care service provision, on average residents rated their General Life Satisfaction as moderately high (GLS mean 7.5 out of 10, SD 2.3). This was influenced by the third of residents who rated very high life satisfaction. There was a significant share (16.9%) of residents who rated their life satisfaction low, at 5 or below on the 10-point scale.

Results from the CASP-12, another measure of quality of life, were also moderately positive (mean total score of 36.8 out of 48, SD 6.2). Nonetheless, looking at the individual items within the CASP-12, a significant proportion of residents felt constrained by their age, a loss of control, left out of things, unable to do what they want, lack a sense of meaning or being able to look forward to each day.

Concerns and complaints

There was a high prevalence of concerns held by residents: 66.8% reported one or more concerns about their care; half indicated at least 2 or more concerns, with an average of 4 concerns. Concerns were common in all domains of aged care and services:

- Concerns about staff were held by 46.7% of residents and included understaffing, unanswered call bells, high rates of staff turnover, and agency staff not knowing the residents and their needs.
- Services and fees were of concern for 39.7% of residents. These were mainly about food and catering or the dining experience, financial charges, and feeling lonely or bored.
- Medical and health care concerns were cited by 26.3% of residents. This included falls and fall prevention, medication management and access to medical professionals.
- Concerns were held about dignity and respect by 23.6% of residents, and being given choice by 17.5%. These included being treated like a child or shouted at by staff, feeling forced to be dependent on staff or wear continence pads, not having specific care needs thought about or listened to, and lack of choice about timing of meals, personal care and lifestyle activities.
- Aspects of the room and facility were of concern for 23.5% and 16.1% of residents respectively, with security, cleanliness, noise and privacy being the most common individual issues.
- Personal care was of concern for 16.9% of residents, including concerns related to showering, grooming, using the toilet, use of continence aids or moving around.
- Residents who said they were bored or lonely were less likely to have visitors daily or a few times a week. The majority of residents reported having visitors at least once a week (73.5%), with 47.3% having visitors at least a few times a week.

Residents were asked whether they had shared their main concerns (up to a maximum of three) with others. Only 52.6% of these main concerns were shared with anyone. The main reasons why concerns were not shared were that residents felt they were 'too minor' (42.5% of main concerns not shared) or residents felt that 'nothing would change' (26.9%) if they were reported. Some of these concerns subjectively assessed as being 'too minor' are things others would consider to be clear examples of substandard care, such as being hurt, treated roughly or shouted at by staff. Of the main concerns that residents did discuss with others, 74.7% were officially reported by the resident (to staff, management or head-office, none to the Aged Care Quality and Safety Commission (ACQSC)) and 39.7% were unofficially reported (mainly to family and friends). Only around

² Courtney et al., 2009

one quarter of the concerns unofficially shared with others (22.6%) were known to have then been officially reported on behalf of the resident (mainly to facility staff, only 1.8% to the ACQSC).

When an official complaint was made, 66.3% were not resolved to the residents' satisfaction. The most cited reason was that 'nothing had changed' since the complaint (56.2%).

Discussion and implications

Ultimately, everyone living in residential aged care has the right to quality of care. Although this study found that the majority of residents are satisfied with the some aspects of the quality of their care, it is clear that a substantial proportion are not. These results highlight the need for action to improve quality of care delivered to those for whom the system is clearly failing.

The survey results suggest that institutional factors play an important role in residents' experiences. Results were consistently best for residents in government RACFs, and usually better for residents in non-profit RACFs than for-profit RACFs. It should be noted that the small number of government facilities in the sample means that these comparisons should be considered indicative, rather than precise, even though the comparisons passed statistical significance testing. Results by facility size were less consistent but overall there was a tendency for RACFs with 0-60 beds to have better resident perspectives than those with 61-100 or over 100 beds.

It is clear that staffing issues (including understaffing, high staff turnover, and family-staff communication) are in need of addressing, as are many other aspects of residential aged care quality and services. Residents' social and emotional needs need to be better addressed, as results revealed that many residents feel lonely or bored, do not feel socially connected, and do not feel that their needs are understood by their RACF. These results underscore the need for enhanced person-centred care in the aged care sector. The survey results also suggest the sector needs more effective management and regulation, including in how complaints are resolved and in monitoring how the system is performing so problems are identified and acted upon.

The survey results provide a benchmark that can be used in monitoring the progress of promised reforms over time. They highlight key issues that can assist in informing efforts to improve the aged care system. It will be important to continue this work by establishing independent, transparent monitoring so that reform of the aged care system is comprehensive, effective and lasting. We should not forget that the systematic problems in aged care were not widely acknowledged or given media attention until recently. Independent, transparent monitoring will help ensure public awareness is maintained, reforms are followed through, and history does not repeat.

1 Introduction

1.1 Objectives

The Royal Commission into Aged Care Quality and Safety's terms of reference include inquiring into the quality of aged care services provided to Australians, the extent to which those services meet the needs of the people accessing them, and the extent of substandard care being provided. As part of this investigation, the Royal Commission contracted the National Ageing Research Institute (NARI), in partnership with Ipsos and the Social Policy Research Centre (SPRC) of the University of New South Wales to undertake two studies to examine the quality of care for people receiving residential aged care, home care or respite care services.

In this, the first of the two studies, the objectives were to explore for residential aged care:

1. Residents' views on their quality of care,
2. Residents' life satisfaction and quality of life, and
3. Residents' concerns and complaints about care, including the reasons concerns go unreported.

To our knowledge, this is the first detailed study of its type that has been conducted independently in Australia about residential care services.

1.2 Background

1.2.1 Residential Aged Care Facilities

Residential Aged Care Facilities (RACFs) provide care to people who can no longer remain living independently at home. They give personal-care services (help with the activities of daily living such as dressing, eating and bathing), health care (such as nursing, allied health and medical care), accommodation (a room and shared areas) and 'hotel' support services (cleaning, laundry and meals). With almost 214,000 residential aged care places as of June 2019³, quality of care is an important consideration for older people, families and society.

1.2.2 Quality in residential care

Quality in aged care is complex and difficult to define. It may include a multitude of aspects including efficiency, effectiveness, safety, comfort, dignity, service accessibility, staff attitudes and behaviour, continuity and reliability of staff, clinical care, physical environment and choice⁴. There are many challenges in assessing quality in aged care. For example, quality may not be immediately apparent or the impacts of acceptable/poor quality care may not become apparent until after a period of time has passed. Quality is a subjective concept and relationships between aged care clients and those providing care may bias objective assessments of quality, and a high level of expertise is required to assess clinical or technical aspects of quality⁵.

Historically, the evaluation of quality in aged care has focused on structural indicators (e.g. staff ratios) and process indicators (e.g. administration of medications). Though the National Aged Care Mandatory Quality Indicator Program focuses on some outcomes of care, these indicators are limited only to unplanned weight loss, pressure injuries and the use of physical restraint. What has not been of core importance are other outcomes of the care provided, including, for example: whether people maintain social connections with the community, whether they are able to choose the services they want to access, or whether their health and wellbeing is being maintained³. There is growing awareness of the importance of measuring outcomes and of

³ Australian Institute of Health and Welfare, 2019

⁴ COTA Australia, 2018

⁵ Fine & Davidson, 2018

capturing the views and experiences of people accessing aged care services. This is reflected in the new Aged Care Quality Standards used by the Aged Care Quality and Safety Commission (ACQSC).

In residential aged care there has often been a focus on discrete priorities such as residents' medical outcomes, well-being, and choice. Patient-reported outcome measures (PROMs)⁶ are gaining prominence as an important way to measure outcomes but have not yet been routinely applied in aged care settings. Measurement of quality of aged care from the perspectives of older people themselves is a developing area with recent advances in instruments such as the CCI-6D⁷, and the ACQSC's Consumer Experience Report which commenced in residential aged care in 2017.

High quality care is viewed as synonymous with 'person-centred care'⁸. It is argued that the core category of person-centred care is 'promoting a continuation of self and normality' and that five content categories contribute to this. These are: 'knowing the person', 'welcoming family', 'providing meaningful activities', 'being in a personalised environment' and 'experiencing flexibility and continuity'. The importance of person-centred care is also underscored by a review of studies examining the factors that influence quality of care. Wells et al. (2019) examined the Australasian Journal on Ageing's published studies about the aged care workforce over a ten-year period and found that the quality of residential aged care can be improved through having better training in person-centred practice, as well as by having enough staff and a supportive staff culture⁹.

1.2.3 Substandard care

Aged care facilities operate within a regulatory regime that requires them to meet minimum standards of quality of care. However, in practice the minimum standards are expressed in a generalised form, have many potential meanings, and there are no formal measures currently available to quantify substandard care in the aged care sector.

Examples of substandard care include not meeting occupational health and safety standards or nutritional standards (including harm resulting from poor food quality or lack of adequate nutritional intake), or adverse health outcomes such as a high rate of mental health concerns, pressure ulcers, over-medication, accidents, or avoidable deaths. Previously reported domains of substandard care in the United States of America's residential aged care setting include dietary services, medical services, rehabilitative services, dental services, pharmacy services, and infection control¹⁰. Substandard care can also involve interpersonal elements, such as how residents are treated and whether their needs, wants and preferences are given due respect.

It is important to note that substandard care also includes elder abuse, whether physical, emotional, or financial. While the exact prevalence of abuse in residential aged care is not known, a 2015 review paper suggests that the prevalence of elder abuse across community settings in the United States ranges between 7% and 10%¹¹, and another study estimates both risk and prevalence in institutional settings as even higher¹². In a study undertaken in the United Kingdom, between 10% and 54% of staff report committing psychological or physical abuse and over 80% of staff report having observed abuse; however, only 2% of abuse was actually reported to management¹³.

⁶ Appleby et al., 2016

⁷ Milte et al., 2017

⁸ Edvardsson et al., 2010

⁹ Wells et al., 2019

¹⁰ Aka et al., 2011

¹¹ Lachs & Pillemer, 2015

¹² Buzgova & Ivanova, 2009; Cooper, et al., 2008

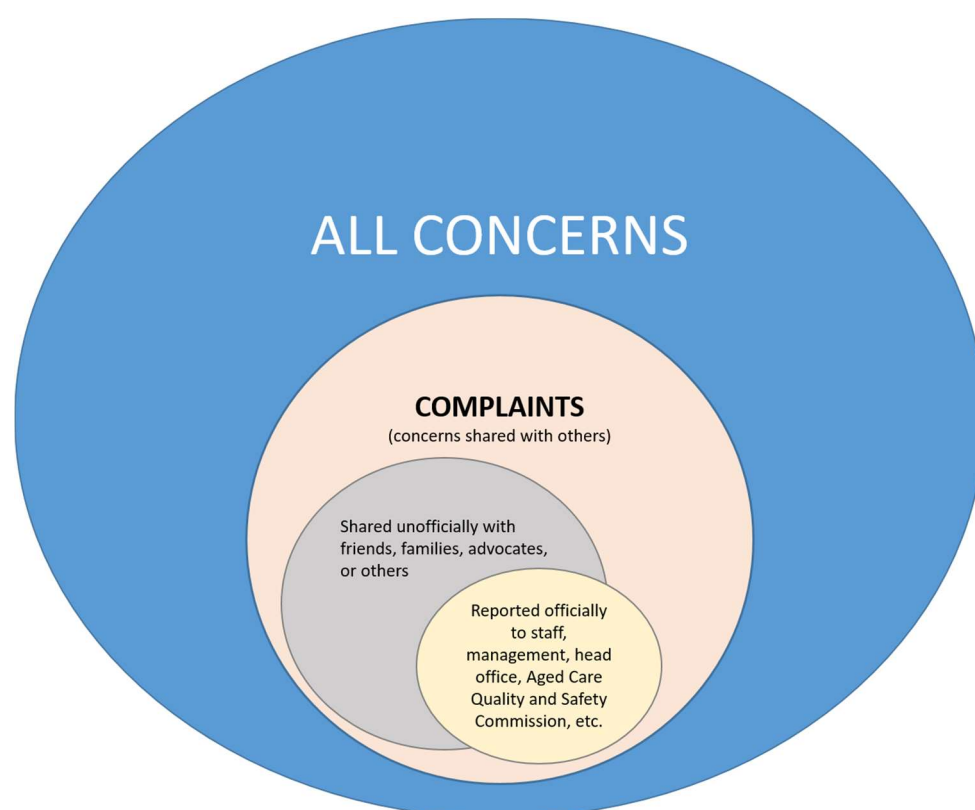
¹³ Buzgova & Ivanova, 2009; Cooper et al., 2008; Natan, et al., 2010

1.2.4 Concerns and complaints

For residents and their families, substandard care is most often expressed in the form of ‘concerns’ and acted upon in the form of ‘complaints’. In Australia, residents and families are able to express dissatisfaction with care by complaining to their facility, and also to bodies such as the ACQSC, My Aged Care, the Older Persons Advocacy Network, and the Commonwealth Ombudsman. For example, in 2018-19, the ACQSC received 5,748 complaints related to residential care, comprising 15,309 issues (as a complaint may relate to more than one issue). The most common issues reported for residential care were: medication management; falls prevention and management; personnel number/sufficiency; personal and oral hygiene; and continence management¹⁴. However, despite this data being available, in-depth information about the complaints, the rate of unreported incidents of substandard care and the reasons why residents and their families or representatives do not report these incidents has not been investigated in a systematic way.

For this study, we were interested in understanding ‘concerns’, defined as residents’ and families’ perceived negative experiences in residential aged care, and ‘complaints’, operationalised as any actions taken to follow up on concerns, both officially and unofficially. A complaint, therefore, can be a concern that has been vocalised unofficially to a friend or family member, or officially to a staff member, management, complaints body, or someone else in a position to do something to resolve that concern (Figure 1).

Figure 1: Concerns and complaints



¹⁴ Aged Care Quality and Safety Commission, 2019a

In principle, complaining about care should lead to both better care for the person making the complaint as well as improvements in the organisation and system. However, making complaints is often viewed in a negative light. A study undertaken in The Netherlands found that long-term aged care residents held negative perceptions of lodging complaints, with the fear that making a complaint could lead to undesirable social consequences¹⁵. This was seen to outweigh and undermine the perceived benefits and efficacy of making a complaint. In recognition of the evidenced hesitations that residents may have in making complaints, the opening sentence of the ACQSC's 'Making a Complaint' webpage states that 'making a complaint is not 'being difficult''¹⁶.

In addition to receiving complaints, the ACQSC uses the Consumer Experience Report questionnaire as a standard tool for monitoring consumer feedback within residential aged care¹⁷. Until December 2019, the surveys were conducted as part of accreditation audits, with auditors interviewing at least 10% of those living in the home, as randomly as possible¹⁸. From December 2019, surveys were conducted as part of compliance monitoring assessment visits. Summary results from the 2018-2019 surveys indicate that residents are generally positive about aspects of the care they receive. For example, when asked how often staff followed up when things are raised, 53.4% of those surveyed said 'all of the time' and 38.6% said 'most of the time'^{19,20}. While consumer experience interviews are important, they do not provide an in-depth exploration of concerns residents may have about their care and the extent to which these concerns are addressed. It is also unclear the extent to which aged care providers influence the selection of those to be interviewed and their responses, even unintentionally.

¹⁵ Bomhoff & Friele, 2016

¹⁶ Aged Care Quality and Safety Commission, 2020 a

¹⁷ Wells et al., 2019

¹⁸ Aged Care Quality and Safety Commission, 2019a

¹⁹ Wells et al., 2019

²⁰ Aged Care Quality and Safety Commission, 2019b

2 Method

Face-to-face interviews were undertaken with a representative random sample of residents or their proxies (family member or nominated representative) in aged care facilities across Australia. The interviews collected demographic information in addition to measuring quality of care, life satisfaction, concerns and complaints and reporting of concerns and complaints.

2.1 Ethics

This project received ethics approval from the Bellberry Human Research Ethics Committee (HREC), application number 2019-09-785.

2.2 Sample selection

A random sample of aged care residents were selected from a random representative sample of aged care facilities.

2.2.1 Sites

Residential aged care facilities (RACFs) were randomly sampled using a random number generator to achieve a nationally representative sample. The sample pool was generated using a publicly available listing of RACFs²¹. Randomisation was proportionally stratified by State/Territory, metropolitan/non-metropolitan areas determined by Greater Capital City Statistical Areas (GCCSA), organisation type (for-profit, non-profit, government), and facility size (number of beds: 0-60, 61-100, >100). Some strata were oversampled to improve the reliability of estimates in those sub-groups. The planned recruitment schedule is shown below in Table 1. RACFs were randomly recruited according to the schedule for a target total of n=130 survey sites.

RACFs were excluded if they were in very remote areas due to difficulty visiting to conduct the face-to-face interviews. Aboriginal and Torres Strait Islander specific RACFs were excluded because there were very few facilities of this type outside of very remote areas. Specialist psychogeriatric RACFs were also excluded due to the specialised population living in these facilities.

Table 1: Planned number of RACFs recruitment by facility type and size (number of beds)

	For-Profit			Government			Non-Profit			Total
Location	0-60	61-100	>100	0-60	61-100	>100	0-60	61-100	>100	
Total Metropolitan	10	11	13	3	2	3	19	18	8	87
Total Regional*	1	3	6	6	2	0	7	11	7	43
Grand Total	11	14	19	9	4	3	26	29	15	130

NB only aggregate numbers are presented in this and subsequent tables to prevent potential identification of individual facilities when reporting results

*no surveys planned for regional NT

2.2.2 Participants

The target number of interviews was n=800. To ensure efficient workloads for interviewers, a minimum number of interviews of n=4 was set at each individual site and some smaller regions were oversampled. The planned number of interviews in each RACF category is shown in Table 2.

Once facilities had been selected and agreed to participate, individual residents were recruited at each facility by drawing a random sample. Participating RACFs were asked to provide a list of all residents' names, room

²¹ Australian Institute of Health and Welfare, 2019

numbers, and the name and contact information of their nominated contact person. This list of room numbers was used to generate a random sample (using a random number generator) of approximately 10% of the residents at each RACF.

There were no age or sex exclusions, but residents who had been in the facility for less than six weeks were excluded. Sensitivity was exercised in cases where RACF management indicated certain residents were easily distressed or who were considered to be at the end of their life, and these residents were excluded. Although specialist psychogeriatric facilities and Aboriginal and Torres Strait Islander facilities were excluded from site selection, Aboriginal and Torres Strait Islander people and residents requiring psychogeriatric care may have been recruited to participate in the survey.

Table 2: Target number of interviews in each RACF category by facility type and size (number of beds)

	For-Profit			Government			Non-Profit			Total
Location	0-60	61-100	>100	0-60	61-100	>100	0-60	61-100	>100	
Total Metropolitan	40	44	140	12	8	32	76	72	96	520
Total Regional*	4	12	60	36	12	0	28	44	84	280
Grand Total	44	56	200	48	20	32	104	116	180	800

*no surveys planned for regional NT

2.2.3 Recruitment procedures

An introductory letter from the Royal Commission was sent to facility managers of the selected facilities. The project team then contacted facilities to follow up and gain written site approval. We followed up with facilities until we received a response accepting or declining the invitation to participate. As participation at the facility or aged care organisation level was voluntary, it is possible that facilities that were underperforming or had serious concerns about their own performance chose not to participate. However, given the relatively low refusal rate (8.8%) of all facilities approached and that direct contact was made with managers at 80% of the contacted RACFs, this does not seem to be a major issue.

Interviewers knocked on the doors for room numbers indicated in the random sample and invited residents to participate in the survey. Where residents were unavailable or not in their rooms at the time of approach, interviewers attempted to reach them three more times before abandoning this room number and approaching the next randomly selected resident room. This approach may bias towards residents with higher levels of frailty or lower physical function given residents who are more active are less likely to be in their room. However, the surveys were conducted when it was likely that residents would be in their room, including outside the times when lifestyle activities are traditionally scheduled.

All participants provided written informed consent. Experienced interviewers were trained by a Clinical Neuropsychologist to determine whether residents had the capacity (including the cognitive capacity) to provide informed consent and to participate in the interview. Where residents were deemed unable to provide consent and complete the interview themselves, their representatives were contacted by phone to complete the interview on their behalf (i.e. as a proxy), either by phone or face-to-face. Information about whether residents had medical diagnoses indicating cognitive impairment or dementia was not requested from RACFs to ensure all residents had equal opportunity to participate and share their experiences. Assessing resident capacity to participate was therefore unbiased by any pre-existing diagnoses. This inclusive approach was extremely important because a key goal of this survey was to understand residents' experiences directly from the residents themselves as much as possible.

Interviewers monitored participants during the interview to ensure that their capacity to understand and participate in the interview did not change. The interviewer was instructed to terminate the interview if, at any stage, the resident displayed any lapse or fluctuation in their capacity to participate, or they wished to stop for any reason.

2.3 Safety and confidentiality

A number of safeguards were put in place to minimise the risk or potential harms to RACFs and residents as a result of their participation:

- Names of people and aged care providers or individual RACFs participating in the survey were not shared outside the project team. Specific regional locations of the participating sites were also kept confidential. No potentially identifying information was shared with the Royal Commission.
- In order to minimise any potential influence from facilities toward residents opting to participate in an interview, residents were approached directly, and aged care providers and facility staff were not informed which residents were invited to participate. It is also for this reason that a 'blanket' approach requesting all resident details was taken (although only details for randomly invited residents were used).
- Specific complaints or incidents of substandard care shared by the residents were not reported to any external organisations. Residents were given resources to lodge formal complaints if they chose, but were clearly informed that the interviewers were not acting on behalf of complaint bodies and were not in any position to act on the complaints they heard.
- Interviewers had current Working with Vulnerable People accreditation and a current Police Check.

2.4 Interview process

Participants completed a Computer Assisted Personal Interviewing (CAPI) survey comprising the questionnaires described in detail below. All interview data were collected by Ipsos interviewers and entered electronically onto a tablet device. Basic demographic questions were collected including age, sex, time living in the RACF, and frequency of visitors. Participants were then asked to complete the questionnaires. The approximate duration of interviews was 60 minutes, which varied depending on the number of concerns or complaints residents described.

2.5 Questionnaires

The interviews used the following questionnaires.

1. **Quality of Care (QoC) questionnaire**²²: an 8-item instrument with a 5-point Likert response scale covering quality of care and confidence about complaints processes.
2. **Consumer Choice Index-6D (CCI-6D)**²³: an instrument designed to capture performance of long-term care facilities across six quality of care dimensions that are important to residents and their families.
3. **General Life Satisfaction (GLS)**²⁴: a single rating out of 10 designed to measure subjective wellbeing and life satisfaction, previously used in the Survey of Health, Ageing and Retirement in Europe study, and for global comparison of life satisfaction.
4. **Control, Autonomy, Self-realisation and Pleasure 12-item (CASP-12) questionnaire**²⁵: an internationally-recognised and validated measure of quality of life in older ages, also used in the Survey of Health, Ageing and Retirement in Europe study.

²² Ratcliffe et al., 2020

²³ Milte et al., 2017

²⁴ Survey of Health, Ageing and Retirement in Europe, 2017

²⁵ Wiggins et al., 2008; Borrat-Besson et al., 2015

5. **Resident Feedback Questionnaire (RFQ):** a new questionnaire developed for this study examining concerns and complaints (the sharing of concerns), including to whom complaints were made and whether they were resolved.

Resident satisfaction and concerns are complex constructs and, as with any study on these topics, these questionnaires have limitations that are important to understand. How satisfaction or concerns relate to aged care services, as opposed to other factors, is not always clear. Different service characteristics may also be more or less important to the satisfaction of different residents depending on their individual preferences, personality, value systems, life experiences or other factors. These traits all may have a substantial impact on the expectations of individual residents and therefore their level of satisfaction and likelihood of reporting concerns. We have not attempted to adjust for this myriad of complex factors as it is not the purpose of this study. Neither have we corroborated the residents' experiences with family or staff perspectives; the purpose of this study was to learn the care recipients' perspectives. Broader research would be useful to develop a more holistic understanding of residential care beyond the resident experience.

2.5.1 Quality of Care (QoC)

Residents were asked to evaluate their experiences of care quality, including their confidence in lodging complaints, using a 5-point Likert scale with the response options: never, rarely, sometimes, mostly, always. The items rated are:

- Treated with respect and dignity
- Supported to make my own decisions about the care and services I receive
- Receive care and support from aged care staff who have the appropriate skills and training
- Receive services and support for daily living that are important for my health and wellbeing
- Supported to maintain my social relationships and connections with the community
- Know how to lodge a complaint
- Comfortable lodging complaints
- Confident that appropriate action will be taken when I lodge a complaint

The questions were developed by and adapted from the work of the Caring Futures Institute at Flinders University. The questions were previously used in a Discrete Choice Experiment for the Royal Commission²⁶.

2.5.2 Consumer Choice Index-6D (CCI-6D)

Quality of care was also measured using the CCI-6D (Table 3)²⁷. The CCI-6D is an instrument designed to capture performance of long-term care facilities across six quality of care dimensions that are important to residents and their families. It has three response options across the domains and is scored using a set of weighted scores that are slightly different depending on whether the resident or their representative answered the questionnaire. The final score is between 0 and 1, with 1 indicating the highest quality of care, and 0 the lowest²⁸.

²⁶ Ratcliffe et al., 2020

²⁷ Milte et al., 2017

²⁸ Milte et al., 2017b

Table 3: CCI-6D questionnaire

Question	Response options
1. How much time are caregiving staff able to spend with me (or my family member)?	- Care staff are always able to spend enough time attending to my individual needs - Care staff are sometimes able to spend enough time attending to my individual needs - Care staff are rarely able to spend enough time attending to my individual needs
2. Do the shared spaces of the aged care home as a whole make you (or your family member) feel 'at home'?	- I feel very at home here - I feel at home here sometimes - I feel at home here rarely
3. Does your own room here make you (or your family member) feel 'at home'?	- I feel very at home in my room - I feel at home in my room sometimes - I feel at home in my room rarely
4. Is there access to outside and gardens in this aged care home?	- I can get outside whenever I want - I can get outside sometimes - I cannot get outside easily
5. How often does the facility offer me (or my family member) things to do that make me feel valued?	- I can do things that make me feel valued often - I can sometimes do things that make me feel valued - I can only rarely or occasionally do things that make me feel valued
6. How flexible is the aged care home with the care routines (e.g. when you or your family member gets out of bed, shower, eat your meals)?	- Care routines are very flexible. The aged care home is very happy to change the times they provide help if I require it - There is a little flexibility in the care routines. The aged care home sometimes changes the times they provide care if I ask for it - There is not much flexibility in the care routines. Care and assistance seems to occur when it most suits the aged care home

2.5.3 General Life Satisfaction (GLS)

Self-reported satisfaction with life was measured using a single question, as adopted in the Survey of Health, Ageing and Retirement in Europe (SHARE) survey²⁹ and the Household, Income and Labour Dynamics in Australia (HILDA) survey³⁰.

Now, thinking about life in general: On a scale from 0 to 10 where 0 means completely dissatisfied and 10 means completely satisfied, how satisfied are you with your life in general?

2.5.4 Control, Autonomy, Pleasure, Self-realisation and Pleasure 12-item questionnaire (CASP-12)

Quality of life was measured using the version of the CASP-12 adapted by the SHARE survey (Table 4)³¹. The CASP-12 has 12 questions and the answers are combined into a final score (minimum final score 12, maximum final score 48). Higher scores indicate higher self-reported quality of life.

²⁹ Survey of Health, Ageing and Retirement in Europe, 2017

³⁰ Ambrey & Fleming, 2013

³¹ Borrat-Besson et al., 2015

Table 4: CASP-12 questionnaire

Dimensions	Questions	Response options
Control	1. My age prevents me from doing the things I would like to	Often Sometimes Rarely Never
	2. I feel that what happens to me is out of my control	
	3. I feel left out of things	
Autonomy	4. I can do the things that I want to do	
	5. Family responsibilities prevent me from doing what I want to do	
	6. Shortage of money stops me from doing the things I want to do	
Pleasure	7. I look forward to each day	
	8. I feel that my life has meaning	
	9. On balance, I look back on my life with a sense of happiness	
Self-realisation	10. I feel full of energy these days	
	11. I feel that life is full of opportunities	
	12. I feel that the future looks good for me	

2.5.5 Resident Feedback Questionnaire (RFQ)

The RFQ was specifically designed for this study in conjunction with the Royal Commission. An advisory panel consisting of aged care staff, aged care residents (from different facilities) and relatives of aged care residents provided feedback during scale development and during pilot testing. The questionnaire is comprised of two components: (A) concerns of the resident (itemised list of concerns), and (B) identifying the three concerns most important to residents and the actions taken regarding those concerns – such as complaints. For Section A, residents are asked to itemise any concerns they may have had in the last 6 months in the following 8 domains:

- being treated with dignity and respect
- personal care
- medical and health care
- choices available to them
- the staff
- their room
- the facility
- the services they receive

Each domain comprises different areas of concern. Residents are asked about each of the areas listed in Table 5 and a ‘yes’ or ‘no’ response recorded for each option. If residents indicated having concerns in a domain not listed, a verbatim response was collected under ‘other’. The questions were scripted to be delivered in a CAPI format (see the Appendix). The questionnaire was customised to make it also suitable for administration to proxies when required. Proxies were asked to answer the survey from the perspective of the resident as best they could, and were given opportunities to separately share their own views as well.

Table 5: Resident Feedback Questionnaire domains and areas of concern

Domain	Areas of concern covered by survey
Dignity and respect	• Feeling forced to be dependent on staff • Being treated like a child • Being forced to wear continence pads • Being shouted at by staff • Not having specific care needs thought about or listened to • Other
Personal care	• Help with showering • Help with eating • Help with using the toilet • Help with mobility • Help with personal grooming • Help with continence aids • Other
Medical and health care	• Seeing a GP • Seeing a dentist • Accessing mental health services • Accessing allied health services • Quality of allied health services • Medication management • Wound care • Use of catheters • Pain management • Falls/falls prevention • Restraint • Other
Choices	• Restriction of activity • Interaction with other residents • Visitors • Personal care • Timing of meals • Lifestyle activities • Other
Staff	• Staff body language/attitude • Staff conduct • Staff or facility culture • Staff turnover, familiarity • Staff training and/or qualifications • Identification of staff • Communication between staff • Cultural sensitivity/awareness • Response to call bell • Rough treatment or pain caused by staff • Staffing level • Use of agency staff • Other
Room	• Safety • Security

Domain	Areas of concern covered by survey
	• Cleanliness and maintenance • Noise • Privacy • Space for visitors • Other
Facility environment	• Facility appearance • Cleanliness and maintenance of equipment, furniture, gardens • Noise level • Safety • Other
Services (food, laundry, lifestyle, cost)	• Food and catering • Dining experience • Social engagement with community • Loneliness and boredom • Wi-Fi and internet • Laundry • Lifestyle activities • Financial fees and charges • Other

If residents identified any concerns in any domain, they were asked to select their top three main concerns. These represent the concerns that were most important to the resident. For each of these three concerns, residents continued to Section B of the RFQ to identify actions taken (that is, any official or unofficial complaints) and resolution, if any. This included identifying whether a resident discussed the concern with another person, for example, a family member or friend, doctor, RACF staff or management, advocate, or official complaint body. In addition, the questionnaire asked for detail about the resolution, if any. Details on resolution of complaints was collected only if a complaint was made to staff, management, organisation, ACQSC or other formal channels. If the respondent reported having shared their concerns with others such as family or friends, but did not formally report the complaint themselves, they were asked if anyone might have formally reported the complaint on their behalf.

At the conclusion of the interview all residents were also asked if they would recommend their RACF to friends or family, and what they liked best about living at their current RACF as a free-response question.

2.6 Statistical analyses

The data set was weighted to be representative of the resident population across Australia. Weights were derived using a 2x3 matrix of the available number of beds from all Australian RACFs for each location type (metropolitan or regional) and organisation type (for-profit, non-profit, government).

The denominator for all weighted percentages from part A of the CFQ was all respondents – this encompasses all concerns identified by the respondents. The 95% confidence intervals for each proportion were calculated. The denominator for all weighted percentages from part B of the CFQ was the total number of main concerns identified by all respondents – this encompasses all results regarding main concerns, reporting and resolution for each of those main concerns.

Analyses were conducted using SPSS Version 26.0³². Descriptive analyses were used to characterise the study sample. Results are presented from analyses conducted on the weighted dataset, unless otherwise indicated. Both weighted and unweighted data were analysed, and there were no large differences in results between the two.

Chi-square analyses were conducted where the measures were categorical to test whether the observed distributions between two categorical measures were statistically significant. ANOVA or Kruskal-Wallis tests were conducted for continuous variables that were either normally or non-normally distributed to test for significant differences in the continuous measure between the different levels of a categorical factor. Due to the negative binomial distribution, total number of concerns per resident was analysed with negative binomial regression. Significance was set at $p < 0.05$ and adjustments were made for multiple comparisons where appropriate.

³² IBM Corp, Armonk, NY

3 Residential care results

3.1 Recruitment

Face-to-face interviews commenced in January 2020 and were to continue until April 2020. However, data collection was stopped mid-March due to the emerging COVID-19 pandemic and associated visitation restrictions to RACFs. Many RACFs had begun to impose their own visitor restrictions ahead of Australian Government recommendations and, recognising the potential risk to residents if fieldwork were to continue, we decided with the Royal Commission to cease face-to-face interviewing and recruitment.

The final survey sample consisted of approximately half of the large-scale intended sample (n=391 of 800 planned, 48.8%). Surveys were conducted in 67 RACFs out of a planned 130 RACFs, with under-representation in some states and regional areas. Despite not achieving the target sample size, the data set has been weighted to be nationally representative; therefore, the overall results, apart from comparisons involving government-run RACFs, have been minimally impacted (Table 6).

Table 6: Representativeness of the survey sample

	Number of interviews conducted	% of total survey sample	% of total resident population in Australia	Weighted % of final survey sample
Geographical location				
Metro	268	68.5	62.3	63.1
Regional	123	31.5	37.7	36.9
Organisation type				
For-profit	135	34.5	40.9	40.9
Non-profit	221	56.5	54.2	54.2
Government	35	9.0	4.9	4.9

The survey was planned to be representative on three variables: provider type, facility size, and remoteness. A breakdown of the provider type for the participating sites and residents shows that around 50% of planned for-profit (24 of 44 sites) and non-profit (38 of 70 sites) RACFs and planned resident surveys at these sites (135 of 300 resident surveys, and 221 of 400 resident surveys, respectively) were completed. However, only about one third of planned government sites (5 of 16 sites) and a third of planned resident surveys at these sites (35 of 100 residents) were conducted.

Regarding facility size, 46% of planned RACFs of size 0-60 (21 of 46 sites) and 50% of planned residents at these sites (98 of 196 residents) participated. About two-thirds (30 of 47 sites) of RACFs with 61-100 beds participated, and nearly 60% of planned individual resident surveys in this category were completed (114 of 192 resident surveys). For RACFs with over 100 beds, 43% of the planned surveys were completed (179 of 412 residents), in line with the proportion of the planned sites of this size that were visited (16 of 37 sites).

Regarding remoteness (i.e. the sampling of RACFs from both metropolitan and regional areas), the actual number of participating sites was about half of what was planned (49 of 87 metropolitan sites, 18 of 43 regional sites). Likewise, about half the number of planned resident surveys were conducted (268 of 520 resident surveys from metropolitan sites, 123 of 280 resident surveys from regional sites). The survey was also planned to be conducted in every state and territory, though no resident surveys were able to be completed in the Northern Territory or regional Western Australia.

The early halting of recruitment also led to under-recruitment of people from culturally and linguistically diverse backgrounds. If the full fieldwork could have been completed, we would have been able to target this cohort to achieve a percentage closer to the expected national percentage.

COVID-19 had the potential to substantially impact the representativeness of the sample. Although there were some impacts, the majority of the categories were still well represented in both the number of RACFs participating and the number of resident surveys conducted there. Because government facilities are under-represented in both the number of facilities and number of resident surveys, any results regarding government facilities should be considered indicative. Despite these caveats and given that we had completed surveys in all other target areas, applied weightings and taken a rigorous approach to sampling and recruitment, we believe the results are generally representative of Australian aged care residents.

3.1.1 Facility recruitment

Interviewers visited 67 RACFs prior to changes in visitation policies (Table 7). A total of 91 RACFs had provided written site approval by the time of fieldwork cessation, representing two-thirds (65.6%) of the RACFs that were approached and invited to participate; however, 24 of those RACFs were not able to be visited before the COVID-19 pandemic began.

The primary difficulty for RACF recruitment besides COVID-19 was contacting the facility or residential manager despite multiple attempts to do so via phone and email over 3 months. In order to increase the response, we expanded the pool of facilities to be sampled. The total number of RACFs approached was 167, with a final contact rate of 80%. The refusal rate was only 8.8% of the RACFs, with the main reasons for refusal being lack of time or capacity to assist in facilitating the survey.

Due to privacy and confidentiality concerns, 16% of the RACFs opted not to provide contact information for resident representatives. At these RACFs, only randomly selected residents who were able to consent and participate for themselves were interviewed.

Table 7: Number of RACFs participating by provider type and size

	For-Profit			Government			Non-Profit			Total
Location	0-60	61-100	>100	0-60	61-100	>100	0-60	61-100	>100	
Total Metropolitan†	6	11	5	0	2	1	9	11	4	49
Total Regional‡	1	0	1	2	0	0	3	6	5	18
Grand Total	7	11	6	2	2	1	12	17	9	67

†No surveys were conducted in metropolitan NT or regional WA

‡No surveys were planned for regional NT

3.1.2 Resident recruitment

A total of 391 interviews were completed (Table 8). Twenty-four (6.1% of the total) were completed by proxies and 5 (1.3%) required an interpreter. Most residents for whom a nominated representative completed the survey were visited daily or a few times a week (89.2%). The use of proxies was lower than anticipated given the prevalence of dementia in residential aged care. In part, this may have been due to some facilities declining to provide contact details of residents' relatives, leading to an oversampling of residents with capacity while awaiting alternative arrangements that would have allowed us to interview proxies for residents without sufficient capacity. Thus, the sample may be biased towards residents who have higher cognitive function. However, it was encouraging that so many residents were able to participate, and that the processes allowed those with some cognitive impairment to participate, although the exact percentage is unknown as information on medical conditions was not collected.

Contact was made with residents 66% of the time that interviewers approached rooms. In the remainder of cases, the resident was out of their room, the approached room was vacant, or the resident was deceased. When contact was made, the consent rate was 41.6%. Twenty percent of residents who were approached declined to participate. Nearly one quarter (23.5%) of approached residents were present but unable to participate independently and no proxy was available. In other instances where interviewers attempted to engage residents but interviews were not initiated, 14.5% of approached residents were either asleep, otherwise engaged, or requested that the interviewer come back to conduct the interview later.

Results related to government-run RACFs are to be treated as indicative due to the small sample of sites participating and interviews conducted in that category. For this reason, statistical interactions between organisation type and facility size were not examined.

Table 8: Number of completed interviews by provider type and size

	For-Profit			Government			Non-Profit			Total
Location	0-60	61-100	>100	0-60	61-100	>100	0-60	61-100	>100	
Total Metropolitan[†]	23	40	60	0	8	13	42	44	38	268
Total Regional[‡]	4	0	8	14	0	0	15	22	60	123
Grand Total	27	40	68	14	8	13	57	66	98	391

[†]No surveys were conducted in metropolitan NT or regional WA

[‡]No surveys were planned for Regional NT

3.2 Demographics

Of the 391 respondents, 252 were female and 139 were male. This represents weighted percentages of 63.4% and 36.6% respectively (Table 9). The majority of participants (74.1%) were between the ages of 75 and 94: 29.8% were between 75 and 84 and 44.3% were between 85 and 94. Just over 9% of respondents were aged 95 years or more and over 3% were under the age of 65.

Nearly 80% of the respondents had been in residential aged care for one year or more. Half were widowed, while 26.9% were married, and 22.7% were divorced or never married. Most (83.8%) of the respondents had children.

Only 11.5% of respondents received visitors daily, though 35.8% received visitors a few times per week, and another 26.2% were visited once per week. Around 20% of residents reported having visitors less than once a week.

Table 9: Demographic characteristics of respondents, n=391

Characteristic	n	Unweighted %	Weighted %
Sex			
Female	252	64.5	63.4
Male	139	35.5	36.6
Age (years)			
45-54	2	0.5	1.2
55-64	9	2.3	2.2
65-74	50	12.8	12.4
75-84	120	30.7	29.8
85-94	166	42.5	44.3
95+	39	10.0	9.2
Prefer not to say	5	1.3	0.8
Time spent in facility			
6 weeks – 6 months	51	13.0	12.4
6-12 months	66	16.9	18.4
1-2 years	79	20.2	20.6
2-5 years	133	34.0	32.1
5-10 years	38	9.7	11.3
More than 10 years	16	4.1	3.7
Don't know	8	2.0	1.6
Marital status			
Single (never married)	42	10.7	11.5
Married/de facto	105	26.9	26.9
Divorced/separated	46	11.8	11.2
Widowed	197	50.4	50.1
Prefer not to say	1	0.3	0.3
Number of children			
0	61	15.6	15.8
1	41	10.5	11.1
2	110	28.1	27.1
3	80	20.5	21.5
4+	96	24.6	24.1
Prefer not to say	3	0.8	0.4
Frequency of visitors			
Daily	46	11.8	11.5
A few times a week	142	36.3	35.8
Once a week	94	24.0	26.2
2-3 times a month	50	12.8	12.8
Once a month	27	6.9	6.2
Less often	20	5.1	4.6
Never	11	2.8	2.6
Don't know	1	0.3	0.2

3.3 Quality of care

In general, the results from the various instruments indicate most residents are satisfied with aspects of their care experience but there is a large share only partially satisfied and a significant minority with low satisfaction.

For individual items on the Quality of Care questionnaire, around 50% of residents were 'always' satisfied except for being treated with dignity and respect (nearly 75%), receiving support for activities of daily living (nearly 65%), and having confidence that action will be taken in relation to complaints (only 44%). In each domain, roughly 20% to 30% of residents were 'mostly' satisfied (Figure 2).

While 74% of residents reported being 'always' treated with dignity and respect, almost 7% reported that they were 'sometimes', 'rarely' or 'never' treated with respect and dignity. Almost 13% said they only 'sometimes' (or less often) received the support to make their own decisions about the care and services they receive. Nearly 16% said they only 'sometimes' (or less often) receive care and support from appropriately skilled and trained staff, while almost 8% said they only sometimes (or less often) received the support and services they felt were important for their health and well-being. Almost 17% mainly felt unsupported in maintaining their social relationships and community connections.

The area in which residents were least satisfied was lodging complaints: between 18% and 23% of residents were satisfied only sometimes (or less often) that they knew how to lodge a complaint, were comfortable lodging a complaint, and were confident that appropriate action will be taken in response. The questions relating to complaints also had relatively large shares of residents unsure how to respond.

When looking at individual residents' responses as a whole, 27.6% were 'always' satisfied in all areas, 39.0% were at least 'mostly' satisfied in all areas (not including 'always') and 33.4% were 'sometimes' or less often satisfied in any area (Figure 3).

Figure 2: Quality of care: percentage by response category

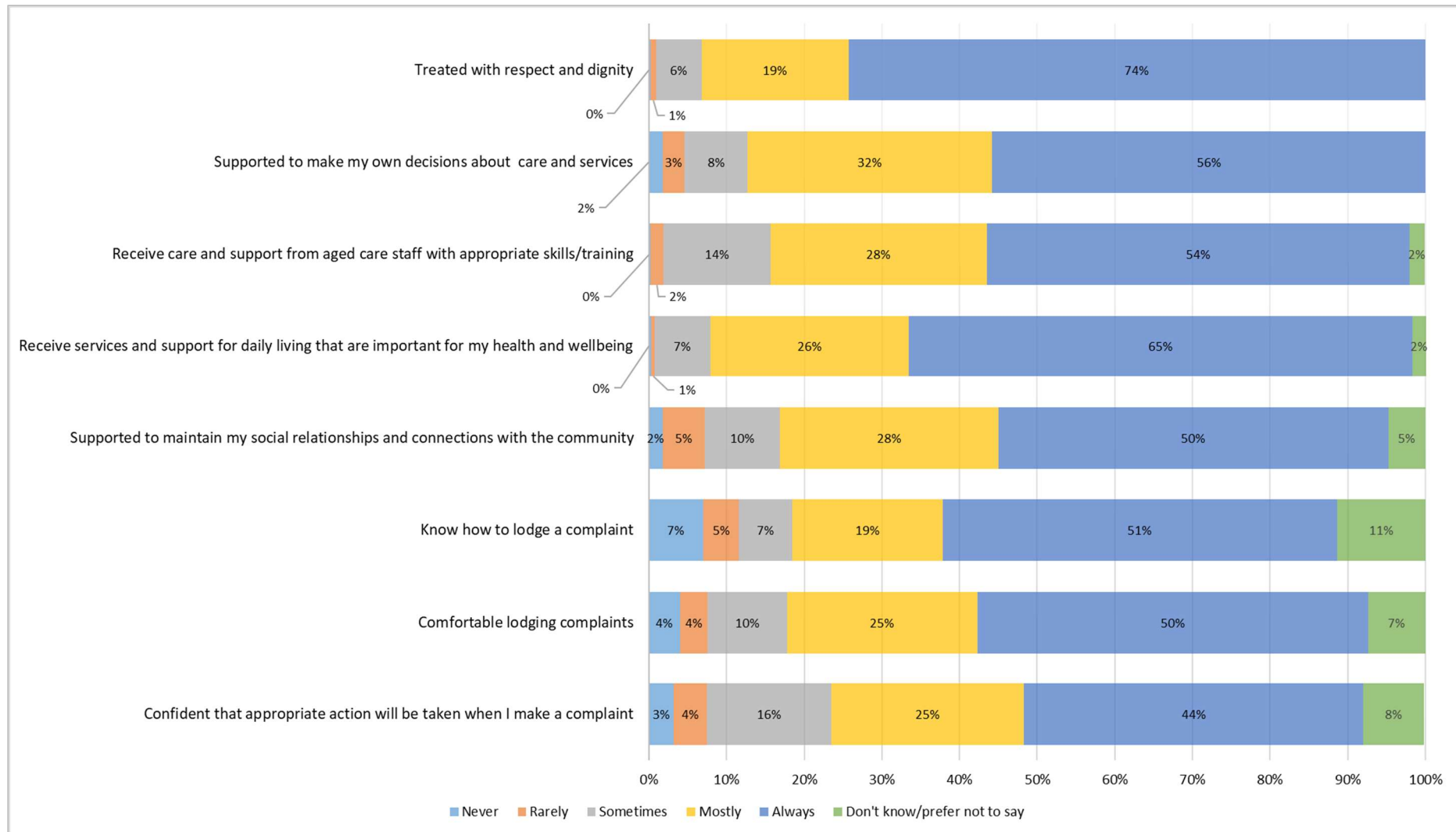
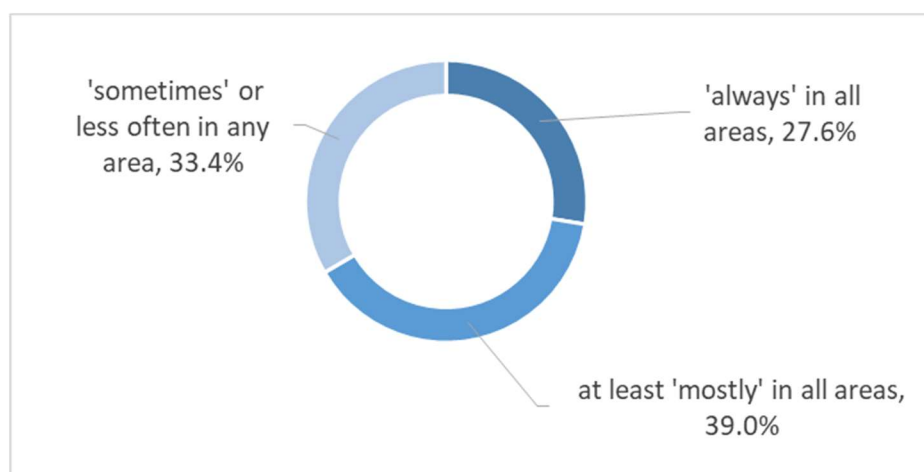


Figure 3: Quality of Care: percentage across areas



NB Excludes responses to complaints related items; excludes 'don't know' answers; 'mostly' category excludes those who answered 'always' in all areas

Residents' overall satisfaction with the care they receive in their RACF ranged from 0 to 1 on the CCI-6D questionnaire, where a score of 1 represents the best quality care. The average score was 0.8 (SD 0.2) with a median of 0.8 (interquartile range 0.6-1.0). Weighted percentages for all responses are shown in Table 10.

Table 10: Resident responses to the CCI-6D

Question and response*	%
Are you satisfied with how much time are care staff able to spend with you?	
Always	58.7
Sometimes	32.1
Rarely	9.3
Do you feel 'at home' in the shared spaces in this place?	
Very*	51.0
Sometimes	29.0
Rarely	20.1
Is your own room here set up to make you feel 'at home'?	
Very*	63.7
Sometimes	25.1
Rarely	11.2
Is there access to outside and gardens in this aged care home?	
Whenever I want*	71.6
Sometimes	16.4
Cannot	11.9
How often does the aged care home offer me things to do that make me feel valued?	
Often*	43.0
Sometimes	40.5
Rarely	16.5
How flexible are staff with the care routines?	
Very*	55.5
A little	32.2
Not much	12.2

*All questions and responses are abbreviated. See CCI-6D in the Appendix for full response options

Pairwise comparisons showed significant differences between all organisation types ($p<0.02$), with residents rating quality of care in government-run RACFs most highly (mean 0.9) followed by non-profit (mean 0.8) and for-profit RACFs (mean 0.7; Figure 4). As with all comparisons involving government-run facilities, results are indicative only. For facility size, RACFs with 61-100 beds were rated significantly lower than those with 0-60 or >100 beds (mean 0.7; Figure 5). No difference was observed between RACFs with 0-60 or >100 beds (means 0.8 and 0.8). There was no difference in resident-rated quality of care between metropolitan and regional locations ($p=0.12$).

Figure 4: Mean CCI-6D total score by facility size

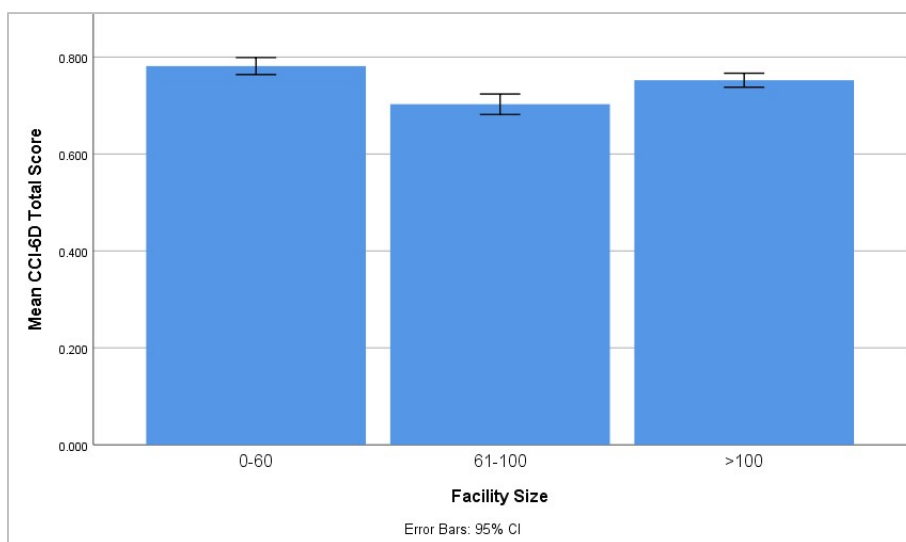
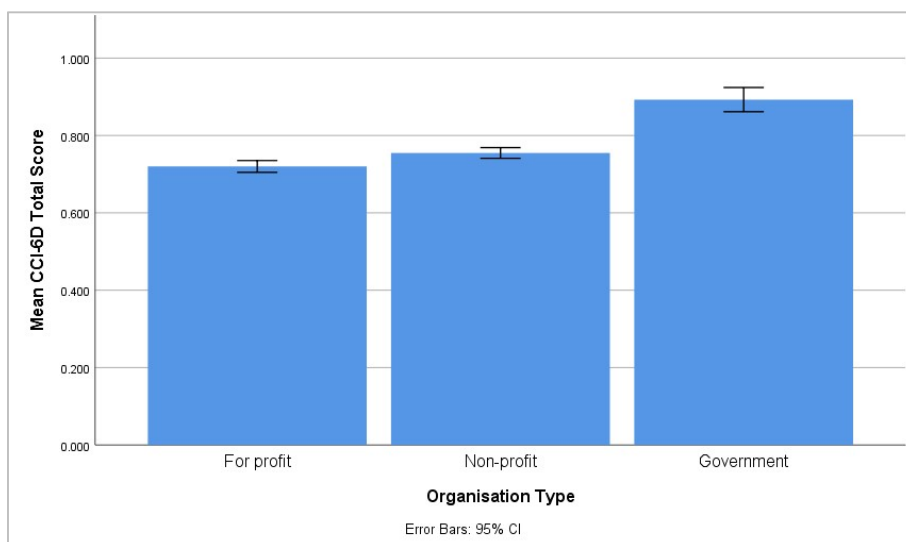


Figure 5: Mean CCI-6D total score by organisation type



At the end of the RFQ, all residents were asked if they would recommend their RACF to friends or family and most said they would (90.1%). All residents were asked what they liked best about living at their current RACF and the most common responses were that staff were very nice (28%) and that the residents felt well-looked after (15%). A small proportion of residents said that there was nothing they liked about living there (4.9%).

3.4 General life satisfaction

Mean general life satisfaction for all residents was 7.5 (SD 2.3) out of 10 with a median of 8 (IQR 7.0-9.0). A third of residents (35.1%) rated their general life satisfaction as 9 or 10. Almost half rated their satisfaction between 6 and 8 inclusive (45.8%). However, 16.9% of residents rated their life satisfaction as 5 or below. This suggests that while there are individuals within residential aged care who report high levels of satisfaction with their life, there are many people for whom life satisfaction is low.

Significant main effects of facility size ($p < 0.001$; Figure 6) and organisation type ($p < 0.001$; Figure 7) were observed with moderate effect sizes. Residents living in small RACFs (0-60 beds) rated their general life satisfaction significantly higher than those living in medium (61-100 beds) and large (>100 beds) RACFs (means 8.1, 7.4 and 7.5, respectively). This represents a decrease in general life satisfaction of 8.6% between the 0-60 and 61-100 bed RACFs, and a decrease of 7.4% between 0-60 and >100 bed RACFs. Pairwise comparisons showed the difference in self-reported life satisfaction between 61-100 and >100 bed RACFs was not statistically significant.

General life satisfaction was rated most highly by residents living in government-run RACFs (mean 8.5), followed by those living in non-profit RACFs (mean 7.9) and for-profit RACFs (mean 7.0). All pairwise comparisons were significant. As residents living in government-run RACFs represent only 4.9% of all residents within Australia, the number of potential residents with such high life satisfaction scores is comparatively small.

While a significant main effect between metropolitan and regional locations was also observed ($p < 0.001$), the magnitude of this difference was small (means of 7.8 for metropolitan and 7.6 for regional) and did not survive adjustment for multiple comparisons ($p = 0.14$).

Figure 6: Mean general life satisfaction by facility size

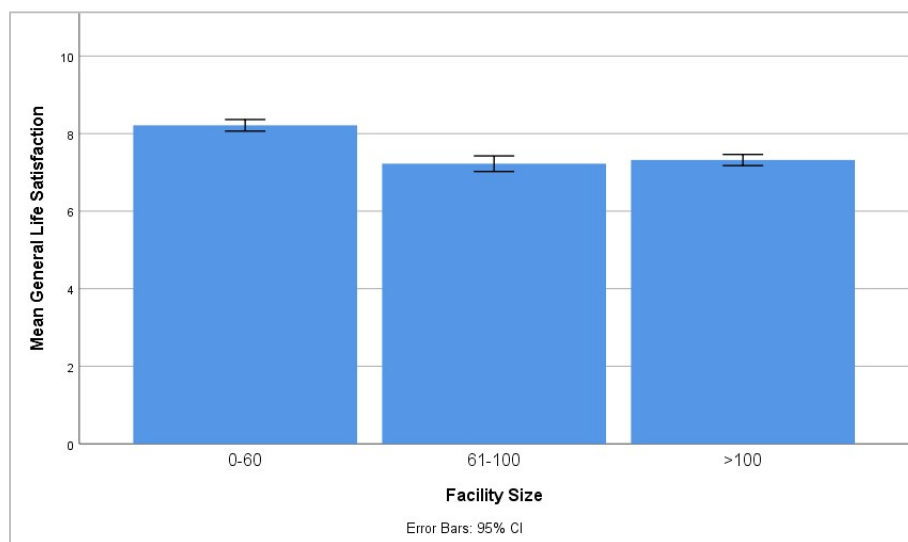
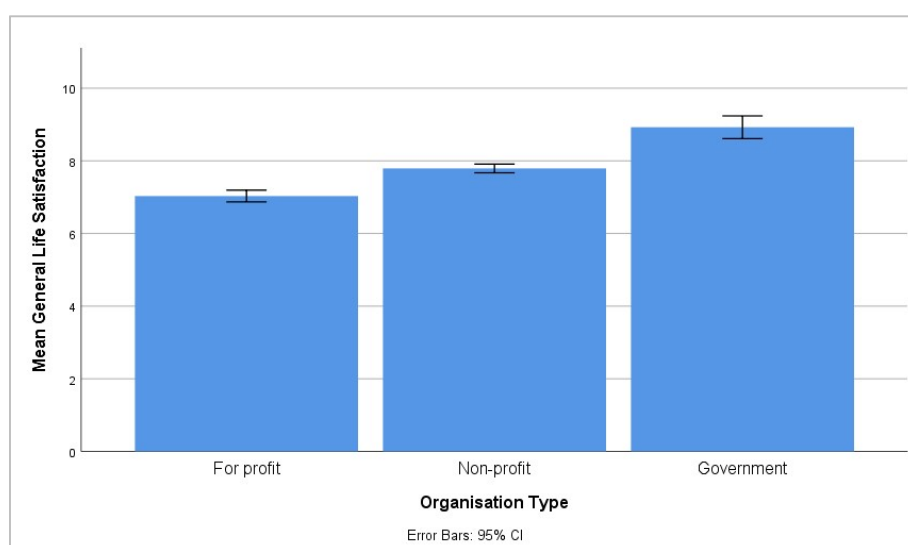


Figure 7: Mean general life satisfaction by organisation type



3.5 Quality of life

Analyses of general quality of life, as measured by the total CASP-12 score, were restricted to participants who responded to every question on the CASP-12 (67% of the total sample). Total CASP-12 scores ranged from 20.0 to 48.0 (maximum = 48.0, highest self-reported quality of life), with a mean of 36.8 (SD 6.2) and a median of 37.0 (IQR 30-40).

There was a significant difference by facility size ($p=0.002$; Figure 8). Pairwise comparisons indicated that this difference was due to RACFs with 0-60 beds having significantly greater self-reported quality of life (mean 37.8) compared to those with both 61-100 (mean 36.5) and >100 beds (mean 36.6).

There was a significant difference between organisation type ($p<0.001$; Figure 9), with self-reported quality of life highest in government RACFs (mean 41.1), followed by non-profit (mean 38.14), and lowest in for-profit facilities (mean 34.8). No significant difference was observed between metropolitan and regional facilities ($p=0.61$).

Results from the CASP-12 are shown in Table 20 in the Appendix. A significant minority of residents felt constrained by their age, a loss of control, left out of things, unable to do what they want, or lack a sense of meaning and being able to look forward to each day. It could not be determined if this relates to poor and/or declining health, as personal information on health status was not collected.

Figure 8: Mean CASP-12 total score by facility size

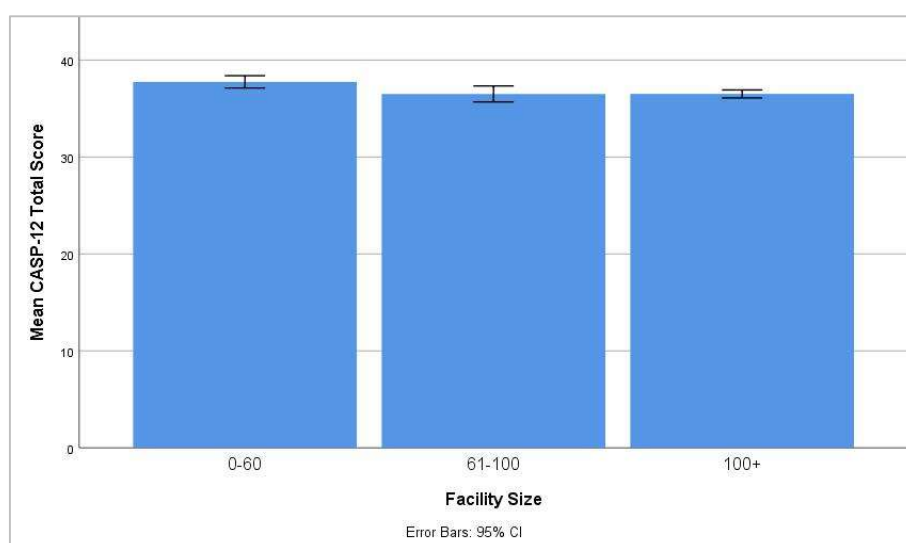
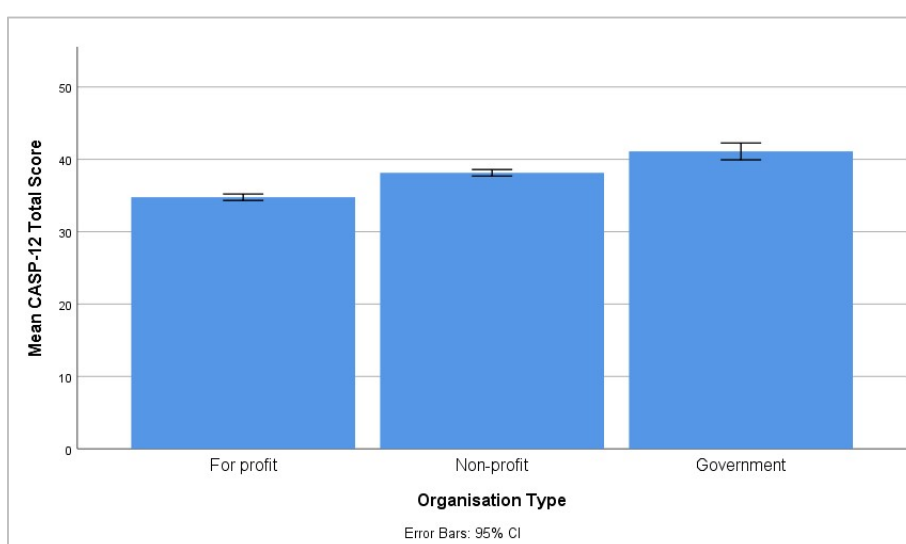


Figure 9: Mean CASP-12 total score by organisation type



3.6 Concerns

3.6.1 Concerns of residents

The number of concerns identified by residents ranged from 0 to 32 from a possible total of 67 (Figure 10). One-third (33.2%) identified no areas of concern at all. Half the residents indicated at least 2 or more concerns (IQR 0-6), with an average of 4 concerns (SD 5.6). Government-run RACFs housed the lowest proportion of residents with at least one concern (49%), followed by non-profit (60.2%) and for-profit RACFs (77.1%).

Concerns were raised across all the areas of residential aged care. The two most common domains of concern were staff (46.7%), which includes understaffing and high turnover, and services and fees (39.7%), which includes food and catering, and residents' social needs. Concerns within the domains of medical and health care, dignity and respect, choice and the room were cited by around 20% of residents. Rates of individual concerns within each domain are shown in Table 11. The 95% confidence intervals around those proportions were not equally distributed around the presented weighted percentage but the overall size of the confidence intervals (i.e. the difference between the lower and upper limits) averaged 1.9% for residents; therefore, there

can be reasonable confidence in the proportions of residents endorsing certain concerns. Table 21 in the Appendix gives further details by organisation type and facility size.

Figure 10: Frequency distribution (percentage of total sample) of number of concerns per resident

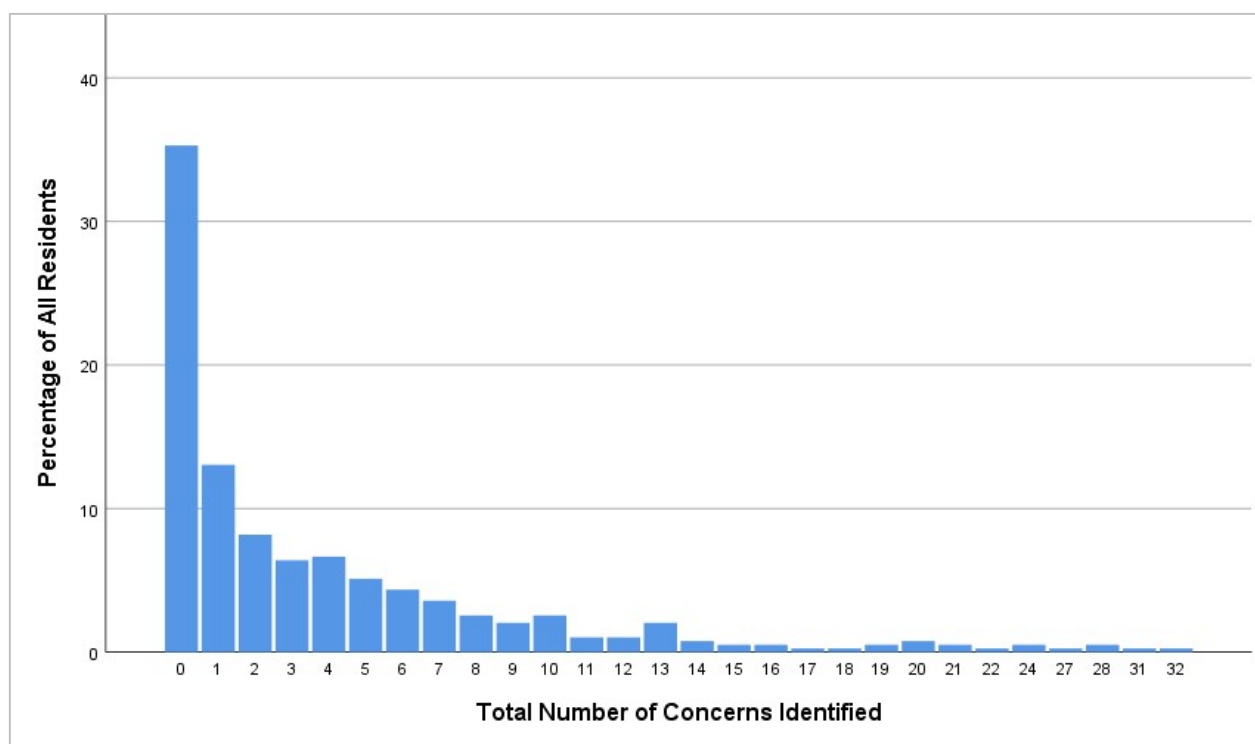


Table 11: Concerns of residents

Domain	% with a concern in this domain (95% CI)	Concerns within domain	% of residents with this concern	95% CI	
				Lower	Upper
Staff	46.7 (44.6-48.8)	Understaffed or not enough staff on duty	34.3	32.3	36.3
		Call bell not being answered	16.6	15.1	18.3
		High rate of staff turnover, or don't see many familiar faces	15.1	13.6	16.7
		Staff not being adequately trained	14.1	12.7	15.7
		Staff name badge/role not being displayed	14.1	12.6	15.6
		Agency staff do not know me and my needs	12.9	11.6	14.4
		Concerns about communication between staff, such as poor handover between shifts	8.5	7.4	9.7
		Staff body language or attitude, like staff being unkind, rude, or unhappy	7.0	6.0	8.2
		Other	6.2	5.2	7.3
		Staff conduct	4.7	3.9	5.7
		Being hurt or treated roughly by staff	3.0	2.3	3.8

Domain	% with a concern in this domain (95% CI)	Concerns within domain	% of residents with this concern	95% CI	
				Lower	Upper
		Staff not being culturally sensitive (caring about my beliefs, values, spirituality, customs or religion)	2.7	2.1	3.5
		Staff culture or facility culture (how staff work together or treat each other)	2.2	1.6	2.9
Services and fees	39.7 (37.6-41.8)	Food & catering	19.4	17.7	21.1
		Feeling lonely or bored	16.0	14.5	17.6
		Quality of laundry services	10.5	9.3	11.9
		Fees and charges (increasing or many additional costs/everything is an extra cost or confusing)	10.3	9.1	11.7
		Dining experience	7.9	6.8	9.1
		Having interesting lifestyle activities	6.1	5.2	7.2
		Other	3.9	3.1	4.8
		Social engagement with the community	2.0	1.5	2.7
		Access and reliability of internet/WIFI	1.9	1.4	2.6
Medical and health care	26.3 (24.4-28.1)	Falls or fall prevention	8.1	7.0	9.3
		The way your medication is managed	7.0	6.0	8.1
		Seeing a GP when needed	5.2	4.4	6.3
		Seeing a dentist when needed	4.6	3.7	5.5
		How pain is managed	4.4	3.6	5.3
		Other	4.2	3.4	5.1
		Accessing allied health services (e.g. physio, podiatry etc.)	2.9	2.3	3.7
		Quality of allied health services (e.g. physio, podiatry etc.)	2.2	1.6	2.8
		How any wounds have been looked after	2.0	1.5	2.7
		Being restrained	1.5	1.1	2.1
		How catheters are used	1.2	0.8	1.8
		Quality of mental health services	1.0	0.6	1.5
		Accessing mental health services	0.8	0.5	1.2
Dignity and respect	23.6 (21.8-25.4)	Feeling forced to be dependent on staff	9.1	8.0	10.4
		Not having your specific care needs thought about or listened to	7.6	6.6	8.8
		Being treated like a child	7.5	6.4	8.7
		Being forced to wear continence pads	4.4	3.6	5.4
		Being shouted at by staff	2.9	2.3	3.7
		Other	2.4	1.8	3.2
Room	23.5 (21.7-25.3)	The security of your room and possessions	9.2	8.1	10.5
		Cleanliness and maintenance of your room and bathroom	9.0	7.8	10.3

Domain	% with a concern in this domain (95% CI)	Concerns within domain	% of residents with this concern	95% CI	
				Lower	Upper
		Noise	7.8	6.7	9.0
		The privacy of your room	5.7	4.8	6.8
		Feeling safe in your room	3.7	2.9	4.5
		Having space for visitors	3.3	2.6	4.1
		Other	3.0	2.3	3.8
Choice	17.5 (15.9-19.1)	Having enough lifestyle activities to choose from	6.1	5.2	7.2
		Choices around the timing of meals	4.9	4.0	5.8
		Choices about how and when you interact with other residents	4.1	3.3	5.0
		Choices about personal care, like choosing when to shower	3.9	3.1	4.7
		Other	2.7	2.1	3.5
		Not being allowed out of bed/chair/room, or not being allowed outside	1.2	0.8	1.8
		Choices about how and when you receive visitors	1.0	0.7	1.5
Personal care	16.9 (15.3-18.5)	How you are helped to shower	10.0	8.8	11.4
		How you are helped with personal grooming, like cutting nails or shaving	6.8	5.8	7.9
		How you are helped to use to the toilet	5.9	4.9	6.9
		How you are helped with continence aids – for example, being changed when they need to be, given enough supplies, or quality of supplies	5.7	4.8	6.8
		How you are helped to get around	5.6	4.7	6.7
		Other	4.3	3.6	5.3
		How you are helped with eating	3.2	2.5	4.0
Facility	16.1 (14.6-17.7)	Noise levels in the facility	9.8	8.6	11.1
		The cleaning and maintenance of equipment, furniture and gardens	5.1	4.2	6.1
		Other	3.6	2.9	4.5
		Safety of the facility	2.7	2.1	3.5
		The overall appearance of the facility	1.9	1.4	2.6

There were significant differences in number of concerns between organisation types. The incidence rate ratio (IRR) when comparing for-profit facilities to non-profit facilities was 0.7 ($p<0.001$, 95% CI=0.6-0.8), indicating that the rate was 28% lower in non-profit RACFs compared to for-profit RACFs. Concerns in government RACFs were 69% lower than in for-profit RACFs (IRR 0.3, $p<0.001$, 95% CI=0.2-0.4) but due to the small sample of government facilities, this is indicative only.

Significant differences in number of concerns per resident were also observed between facility sizes ($p<0.001$). The IRR for the comparison of RACFs with 60 or fewer places compared to those with 61-100 was 1.5 ($p<0.001$, 95% CI = 1.3-1.8) indicating that the rate of concerns was 50% higher in RACFs with 61-100 places compared

to those with less than 60 places. The IRR for the comparison between 60 or fewer with RACFs with >100 places was 1.2 (p=0.048, 95% CI=1.0-1.4), indicating that the rate of concerns was 16% higher in RACFs with >100 residential places compared to ones with less than 60 places.

3.6.2 Concerns of representatives

When the survey was completed by a proxy/representative (n=24), the representatives identified between 0 to 9 concerns. The mean number of concerns was the same as for residents at 4 (SD 3.2) and the median was 3 (interquartile range 1.0-8.0). Representatives were more likely to identify one or more concerns than residents (15% of the representatives identified no concerns, which is approximately half the rate for residents) but the small numbers of proxy respondents limit generalisability.

The most common concerns of representatives related to staff (81.3%) and poor staff/family communication (41.1%) as shown in Table 12. Concerns about the living space (mainly cleanliness), medical and health care, and fees were also cited by roughly one fifth of representatives. The 95% confidence intervals around the proportions averaged 10.4% in overall size for proxy respondents, which were wider than the confidence intervals for residents. The small number of proxy respondents may limit generalisability of the concerns they shared during the survey.

Table 12: Concerns of resident representatives

Domain	% with a concern in this domain (95% CI)	Concerns within domain	% of representatives with this concern	95% CI	
				Lower	Upper
Staff	81.3 (74.7-87.4)	Always repeating myself/staff don't relay information to one another	45.1	37.1	53.3
		Staff name badge/role not displayed	39.9	32.3	48.3
		Staff don't listen or act on family requests or feedback	32.0	24.5	39.7
		Family can never find a staff member	30.2	23.2	38.2
		Other	22.8	16.3	29.9
		Poorly trained/unqualified staff	22.5	16.3	29.9
		Call bells not answered	14.8	9.7	21.3
		Issues with an individual staff member	14.6	9.7	21.3
		Staff attitude/body language toward family	14.6	9.7	21.3
		Not culturally sensitive to family	11.9	7.4	18.1
		Staff culture or facility culture (how staff work together or treat each other)	11.3	6.9	17.2
		Poor team work	11.0	6.9	17.2
Staff and family communication	41.1 (33.0-49.0)	Not enough/no discussion or sharing of care plans with family	25.9	19.4	33.7
		Other	22.5	16.3	29.9
		Transparency	18.6	12.6	25.3
		No timely feedback to family	15.3	10.3	22.1
		Family not given any/enough/timely information	10.7	6.3	16.4
Living space	26.2 (19.4-33.7)	Cleaning and maintenance of room and equipment	26.2	19.4	33.7

Domain	% with a concern in this domain (95% CI)	Concerns within domain	% of representatives with this concern	95% CI	
				Lower	Upper
		Nowhere for family to sit/socialise	4.0	1.8	8.5
		Other	4.0	1.8	8.5
		Restricted visiting hours	0.0	0.0	0.0
Medical or health care	18.9 (13.2-26.1)	GP not accessible/frequent/contactable for family	18.9	13.2	26.1
		Other	7.9	4.2	13.0
Fees	18.8 (13.2-26.1)	Financial fees and charges	18.8	13.2	26.1
		Other	7.6	4.2	13.0
Respect and being informed	11.5 (6.9-17.2)	Family not consulted about how the facility operates	11.5	6.9	17.2
		Other	7.9	4.2	13.0
Amount of choice and input	7.3 (3.7-12.1)	Other	4.0	1.8	8.5
		Family expected to participate too much in care (e.g. short staffed or don't do tasks)	3.4	1.4	7.5
		Family not allowed to participate enough in care (e.g. not allowed to feed resident)	0.0	0.0	0.0
		Decisions made about resident without family consultation	0.0	0.0	0.0

3.6.3 Other concerns

Under each of the domains, residents or proxies were asked if they had any 'other' concerns. Example responses are provided below in Table 13. These free responses are not to be taken as representative of the population. However, one 'other' concern that did emerge consistently related to residents having difficulty communicating with staff when it was perceived that staff did not speak English well. While this represents a small proportion of the total number of residents surveyed (2.2%), it is possible that this is an underestimation as this concern emerged without prompting.

Table 13: Examples of 'other' concerns

Domain	Example responses
Dignity and respect	'Sometimes they do not answer the call bell for up to ½ hour and leave me on the toilet too long' 'heard staff shouting at other residents...that concerns you' 'the longer I'm here, the better they know me and the better they treat me'
Personal care	'Dentures not put on by staff' 'Not enough continence pads in the cupboard' 'Often he is not shaved'
Medical and healthcare	'In the years in the facility, he has not been asked if he needs to visit the dentist who comes to the facility' 'GP seemed too busy to spend enough time with me' 'He could not reach call bell and fell out of bed. Doctor came and said rest and did not come back. After a week he went to hospital and he had fractured something'
Staff	'They favour certain residents.'

Domain	Example responses
	'Staff do not speak English or understand English, and speak too quietly.' 'One time one of the agency staff gave another patient my cancer injection instead of me'
Room	'The noise from other residents can be annoying and continuous' 'Been promised a heater in bathroom about 3 years ago but nothing has been done' 'There's no room to easily get to the toilet with walker' 'No air conditioning in bedroom'
Facility	'Some residents get violent towards other residents and you need to be careful not to talk to them or be near them.' 'a lot of chairs in the dining room are covered with food stains...some chairs in dining and lounge rooms are wet with urine' 'feel unsafe around other residents'
Fees and services	'Most activities require better vision than I have' 'Always seems to be extra costs, but not always informed as to what they are' 'Excessive fees, there must be a better system'
Choice	'Activities are geared to the older residents. Lack of activities for residents that are mentally capable.' 'Sometimes there are too many rules that takes away the ability to make your own choices. And I should be allowed to decide when you want to do stuff. Problems between management and staff.'

3.6.4 Correlation with life satisfaction and quality

Negative correlations were observed between the scores on life satisfaction, quality of care and general quality of life measures and respondents' total number of concerns. A greater number of concerns was associated with lower GLS ($r=-0.39$, $p<0.001$), lower perceived quality of care on the CCI-6D ($r=-0.43$, $p<0.001$), and lower self-reported quality of life on the CASP-12 ($r=-0.43$, $p<0.001$).

3.7 Main concerns

Main concerns are those identified by the residents as their most important concerns (up to a maximum of three). The average number of main concerns was 1.6 (SD=1.3). Approximately one-third (33.5%) of residents indicated that they had no main concerns after identifying all of their concerns in the first part of the questionnaire (Figure 11).

The number of main concerns was significantly different between facilities of different sizes ($p<0.001$; Figure 12). Pairwise comparisons indicated that RACFs with 0-60 beds had a significantly lower number of main concerns compared to the larger facilities (both 61-100 and >100 ; $p<0.001$), which were not significantly different from each other. The means by facility size in increasing order were: 1.3 (0-60 beds), 1.7 (>100 beds) and 1.7 (61-100 beds).

Significant differences in number of main concerns were also observed between organisation types ($p<0.001$; Figure 13). Pairwise comparisons indicated significant differences between all three organisation types (each $p<0.001$). The means, in increasing order, were 1.0 (government), 1.4 (non-profit), and 1.9 (for-profit). No significant differences in the number of main concerns were observed between RACFs in metropolitan areas (mean 1.6) or regional areas (mean 1.6; $p=0.24$).

Figure 11: Number of main concerns identified by residents

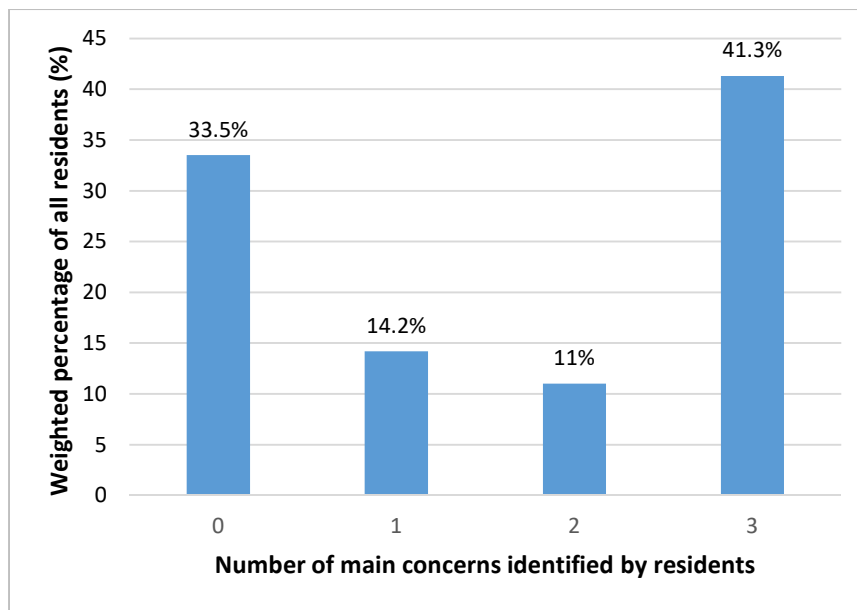


Figure 12: Number of main concerns identified by facility size

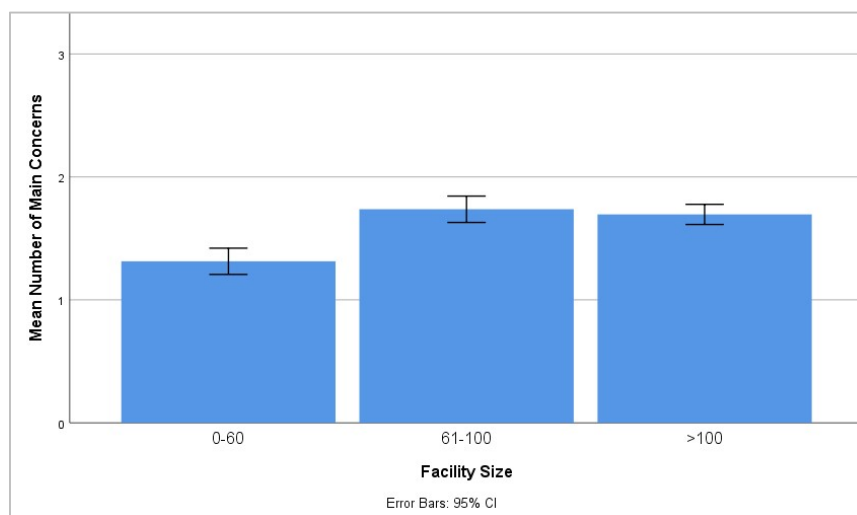
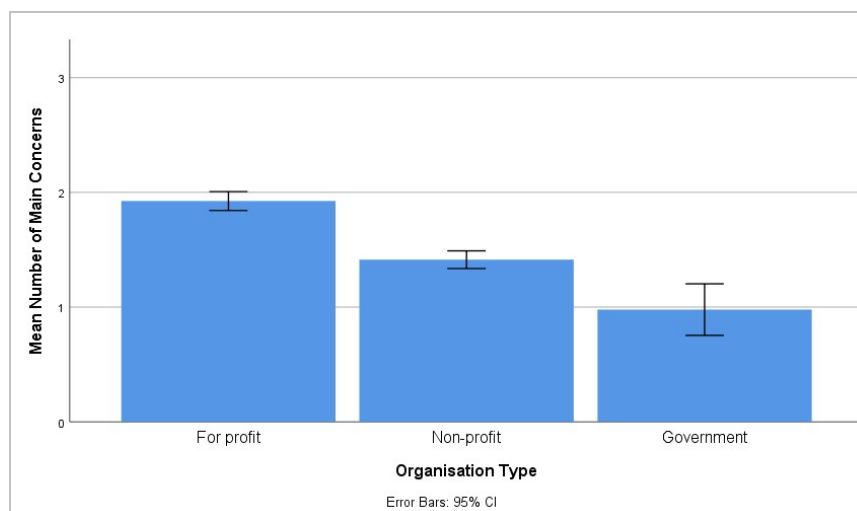


Figure 13: Number of main concerns identified by organisation type



Overall, residents living in RACFs that are either for-profit organisations or RACFs with more than 60 residential places identified the greatest number of main concerns. For-profit RACFs with >100 beds had the highest average number of main concerns (mean 2.2); however, the interaction between organisation type and facility size was not statistically examined due to insufficient sample sizes for the government RACFs.

Table 14 shows the percentage of respondents identifying each concern out of the total number of main concerns identified across the whole sample. The concerns most commonly deemed to be of high importance by residents related to staff and the services and fees. Main concerns about staff were particularly about organisational factors such as the number of available staff, staff training and lack of familiar faces. It must be acknowledged that poor treatment by staff was a main concern for some residents, but less frequently reported than concerns related to under-resourcing. Main concerns relating to services and fees were most often about the food and catering or residents feeling lonely or bored.

Table 14: Main concerns – aged care facility residents

Concern	% of all main concerns	Domain
Understaffed or not enough staff on duty	13.4	Staff
Food and catering	9.9	Services and fees
Feeling lonely or bored	6.1	Services and fees
Staff not being adequately trained	4.2	Staff
Your call bell not being answered	3.9	Staff
High rate of staff turnover, or you don't see many familiar faces	3.2	Staff
Quality of laundry services	2.8	Services and fees
Noise levels in the facility	2.6	Facility
How you are helped to shower	2.5	Personal care
The security of your room and possessions	2.4	Room
Staff name badge/role not being displayed	2.3	Staff
Fees and charges	2.2	Services and fees
Agency staff do not know me and my needs	1.9	Staff
Other concerns about staff	1.9	Staff
How you are helped to use to the toilet	1.7	Personal care
Staff body language or attitude, like staff being unkind, rude, or unhappy	1.6	Staff
Noise	1.5	Room
Other concerns about medical and health care	1.5	Medical and health care
How you are helped with personal grooming, like cutting nails or shaving	1.4	Personal care
Concerns about communication between staff, such as poor handover between shifts	1.4	Staff
How you are helped to get around	1.4	Personal care
Choices about your personal care, like choosing when to shower	1.4	Choice
Having interesting lifestyle activities	1.4	Services and fees
Falls or fall prevention	1.4	Medical and health care
The way your medication is managed	1.3	Medical and health care
Dining experience	1.3	Services and fees
Being treated like a child	1.3	Dignity and respect

Concern	% of all main concerns	Domain
Having enough lifestyle activities to choose from	1.3	Choice
Seeing a GP when needed	1.2	Medical and health care
Cleanliness and maintenance of your room and bathroom	1.2	Room
Choices around the timing of your meals	1.2	Choice
Other concerns about services and fees	1.2	Services and fees
Feeling forced to be dependent on staff	1.1	Dignity and respect
Other concerns about choice	1.1	Choice
How your pain is managed	1.1	Medical and health care
Other concerns about the room	1.0	Room
Seeing a dentist when needed	1.0	Medical and health care
Being forced to wear continence pads	0.9	Dignity and respect
The privacy of your room	0.9	Room
Not having your specific care needs thought about or listened to	0.9	Dignity and respect
Other concerns about dignity and respect	0.9	Dignity and respect
Other concerns about personal care	0.8	Personal care
How you are helped with continence aids	0.7	Personal care
Being hurt or treated roughly by staff	0.6	Staff
Being shouted at by staff	0.6	Dignity and respect
Feeling safe in your room	0.6	Room
Choices about how and when you interact with other residents	0.6	Choice
Accessing allied health services (e.g. physio, podiatry etc.)	0.6	Medical and health care
Safety of the facility	0.5	Facility
Choices about how and when you receive visitors	0.3	Choice
How any wounds have been looked after	0.3	Medical and health care
Other concerns about the facility	0.3	Facility
Having space for visitors	0.2	Room
How you are helped with eating	0.2	Personal care
How catheters are used	0.2	Medical and health care
Not being allowed out of your bed/chair/room, or not being allowed outside	0.2	Medical and health care
Staff culture or facility culture (how staff work together or treat each other)	0.2	Staff
The cleaning and maintenance of equipment, furniture and gardens	0.2	Facility
Social engagement with the community	0.2	Services and fees
Being restrained	0.1	Medical and health care
Accessing mental health services	0.0	Medical and health care
Quality of mental health services	0.0	Medical and health care

3.8 Reporting of concerns

3.8.1 Complaints

Half (52.6%) of the main concerns raised by residents were reported or shared with others (i.e. became complaints), regardless of whether this was through official channels or unofficially, for example with family or friends. See Figure 14 for a flow diagram of the key results of this part of the questionnaire and Table 22 in the Appendix for further details about which main concerns became complaints, how they were reported and if they were resolved.

The main concerns most often discussed with others or reported (as a share of all complaints) were:

1. Below standard food and catering (13.8%)
2. Understaffed or not enough staff on duty (12.4%)
3. Staff not being adequately trained (6.3%)

See Table 22 in the Appendix for a full list – only concerns with a proportion greater than 5.0% are listed above. Residents living in 0-60 bed RACFs had the lowest rate of making complaints (whether official or unofficial; 47.5% of all concerns in this facility size became complaints). RACFs with 61-100 and >100 beds showed similar rates of complaining about their concerns (57.5% and 52.1%, $p < 0.001$).

3.8.2 Unreported concerns

The main concerns most often not shared or reported (as a share of all unreported main concerns) were:

1. Understaffed or not enough staff on duty (14.5%)
2. Feeling lonely or bored (8.9%)
3. Below standard food and catering (5.5%)
4. High rate of staff turnover, or you don't see many familiar faces (5.5%)

Only those with a proportion greater than 5.0% are listed above (see Table 22 in the Appendix for a full list). The reasons that concerns were not reported are listed by frequency in Figure 14. Respondents were able to give multiple reasons why each concern was not reported. The main reasons residents did not share their concerns with others was that they believed it was too minor (42.5%), they did not think anything would change (26.9%), and/or they did not want to be a nuisance (17%). A relatively high proportion of concerns were also not reported because residents did not know to whom their concern should be reported (9.4%), did not know how to report (6.1%), and/or feared repercussion (2.8%).

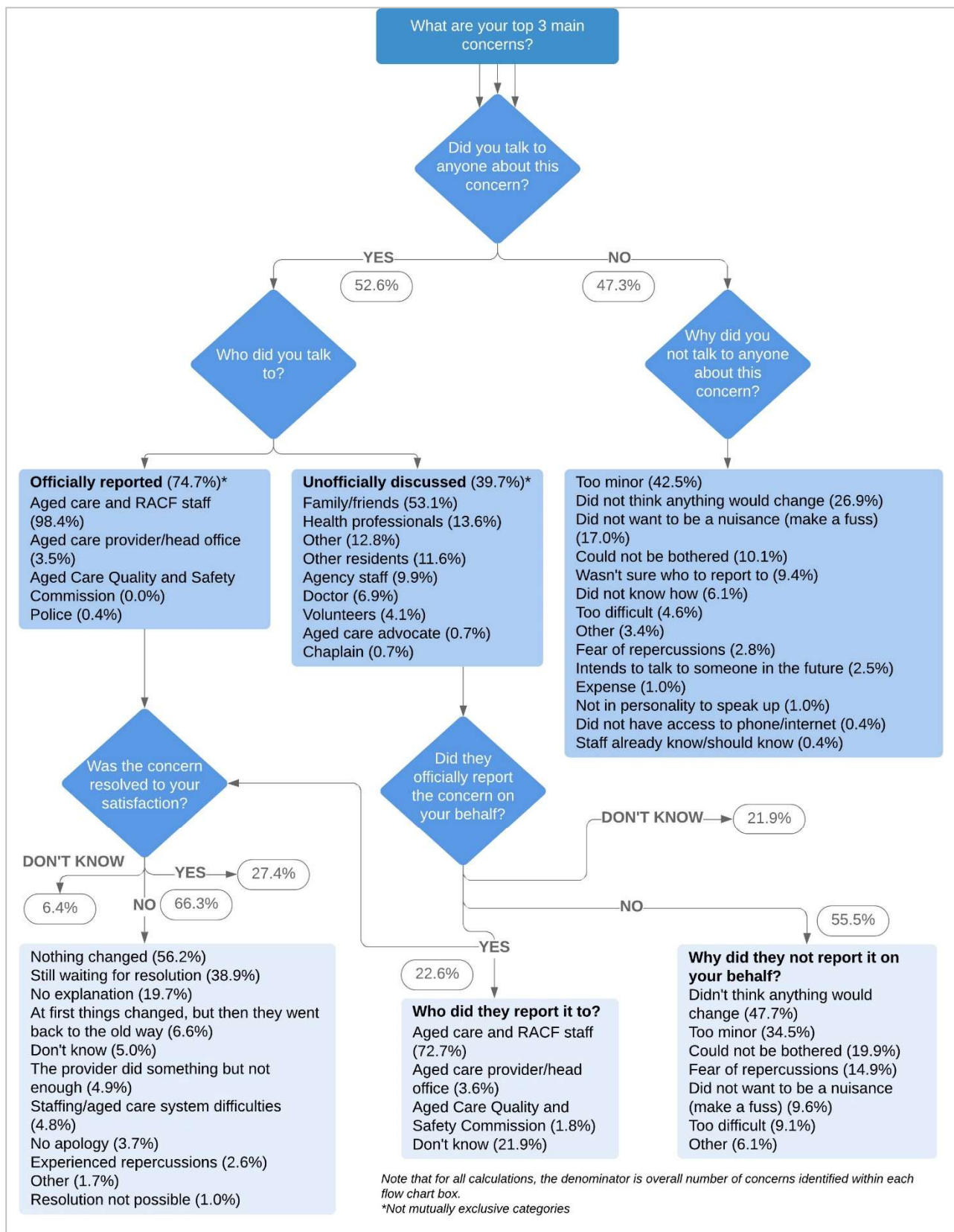
The top main concerns not shared because residents felt they were too minor (as a share of all such concerns) were:

1. Feeling lonely or bored (9.8%)
2. High rate of staff turnover, or you don't see many familiar faces (7.8%)
3. Understaffed or not enough staff on duty (7.1%)
4. How you are helped to shower (5.7%)

The top main concerns that were not shared because residents felt that nothing would change (as a share of all such concerns) were:

1. Understaffed or not enough staff on duty (22.8%)
2. Feeling lonely or bored (13.4%)
3. High rate of staff turnover, or you don't see many familiar faces (8.5%)
4. Call bell not being answered (7.2%)
5. Food and catering (6.1%)
6. Agency staff do not know me and my needs (5.0%)

Figure 14: Flow chart of responses regarding reporting and resolution of concerns for residents



Free response answers given by residents provide some further insight into why they did not report concerns. Some things they perceived as being 'normal', such as understaffing, led to them not speaking to others about it. With regard to staffing concerns, some residents also indicated that they did not say anything about these concerns because they felt it was the job of the managers and not for them to discuss. Some residents chose not to speak about their concerns because 'they already know' and 'enough others complain', suggesting that their silence may reflect a sense of futility in speaking up. Some residents indicated that it was not in their personality to complain. One resident said that they 'hadn't been here long, so thought [I] should keep my mouth shut'. A very small minority of residents thought that displaying their dissatisfaction (e.g. toward the food) was enough indication of a complaint and nothing further needed to be said, but one resident acknowledged that perhaps staff 'weren't getting the message'. Another resident felt that they would not be heard if they complained because of having a strong non-Australian accent and that communication with staff whose first language is not English was a struggle.

3.8.3 Recipients of complaints

For each concern, a complaint could be made to multiple recipients. A complaint could be vocalised unofficially to a friend or family member, and/or officially to a staff member, management, complaints body, or someone else in a position to do something to resolve that concern. Official reporting of complaints occurred for 74.7% of all complaints, while 39.7% were shared unofficially (22.2% of complaints were shared both officially and unofficially).

Official reporting was less likely to occur in RACFs with 0-60 beds (60.3% of all complaints in this facility size were reported officially) compared to those with 61-100 or >100 beds (71.5% and 83.0%; $p<0.001$). Smaller RACFs were also less likely to have made unofficial complaints (33.0% of all complaints in this facility size were made unofficially) compared to 61-100 (40.6%) and >100 bed (42.0%) RACFs ($p=0.10$). These likely reflect that people living in RACFs with 0-60 beds were less likely to have talked about their concerns with anyone compared to the larger RACFs.

For-profit RACFs showed the highest proportion of concerns being reported officially (85.0% of all complaints in this organisation type were reported officially), compared to non-profit (66.4%) and government (63.5%) RACFs ($p<0.001$). In for-profit RACFs, concerns were also less likely to be shared unofficially with others (32.5% of all complaints in this organisation type), compared to government (36.5%) and non-profit (46.2%) RACFs ($p<0.001$). This requires further examination to understand why this occurred, which was beyond the scope of the current project.

Most complaints officially reported were to staff at the facility (73.5% of all complaints or 98.4% of all official complaints), with very few to the RACF provider head office (2.6% of all complaints or 3.5% of all official complaints). No resident indicated that they had directly reported their complaints to the ACQSC. Friends and family were the most common recipients of unofficial complaints (21.6% of all complaints or 53.1% of all unofficial complaints), followed by health professionals (5.5% of all complaints or 13.6% of all unofficial complaints). Concerns shared with other residents (4.7% of all complaints or 11.6% of all unofficial complaints) may be underestimated because it was not a prompted item in the questionnaire. One resident reported directly to police; however, this was also an unprompted item in the questionnaire. See Figure 14 for the proportions of complaints as a share of whether they were officially or unofficially reported.

3.8.4 Complaints on behalf of residents

Of the concerns that were only shared with others in unofficial capacities, nearly one quarter (22.6%) were then officially reported on behalf of the resident. The majority of these complaints were raised with RACF staff (72.7%), 3.6% were reported to the RACF provider head office, 1.8% were reported to the ACQSC, and 21.9% of the complaints were reported but residents did not know to whom.

Whether complaints were likely to be reported on behalf of residents depended on with whom residents shared these concerns (Table 15). When residents spoke to aged care advocates or to the police, the complaints were officially reported on their behalf 100% of the time, although very few concerns were taken through those paths (0.6% combined). Residents indicated that health professionals did not report any concerns on behalf of residents. The reason for this, and whether it may reflect particular rules about complaint disclosure in those professions, is unknown; however, some residents said that health professionals clearly indicated that their concerns would not be passed on. A high proportion of family/friends did not report officially on behalf of residents, and free responses suggest one reason was family and friends left it up to the resident to make that decision, or would not do so without permission of the resident.

Table 15: Concerns reported on the residents' behalf

Who resident spoke to unofficially about the concern	Reported officially on the residents' behalf?		
	Yes (%)	Don't know (%)	No (%)
Family/friends	30.5	11.9	57.6
Health professionals	0.0	0.0	100.0
Other residents	12.6	30.3	57.1
Agency staff	18.3	38.8	42.9
Doctor	83.8	16.2	0.0
Volunteers	0.0	50.0	50.0
Aged care advocate	100.0	0.0	0.0
Police	100.0	0.0	0.0
Chaplain	0.0	100.0	0.0
Other	3.5	37.8	58.7

3.8.5 Resident characteristics that influence reporting

Sixty percent of interviewed residents shared at least one of their main concerns with another person, whether officially or unofficially. The proportion of residents who shared their concerns steadily decreased with increasing age: 83.9% of residents aged 55-64 years, 71.5% of those aged 65-74 years, 64.5% aged 75-84 years and 24.5% of those aged 95+ shared their concerns. The same pattern is observed when considering the number of concerns residents had, such that the oldest age groups had the least number of concerns. This could reflect a number of different things. For example, residents in the oldest age group could have grown up in a generation where complaining was discouraged. These residents may feel resigned because they believe nothing will happen as a result of their complaining or that their complaints would not be heard due to their age³³.

The relationship between resident age and official reporting of concerns was somewhat similar. Residents in the 55-64 year age group were the most likely to officially report concerns (64.5%), whilst the oldest age group was least likely to officially report concerns (18.6%). No clear pattern of decreasing likelihood in the interim age groups was found, as most other age groups were around 50%.

Males were more likely to make complaints than were females (Odds Ratio 1.08, CI 1.02-1.15, p=0.01). The proportion of men who did not share their concerns with others was 53.1%, compared to 64% for females.

³³ Aronson, 2006

This gender difference increases for making official complaints: 59.6% of males did not officially report their concerns compared to 72.2% of females.

Widowed residents were less likely to share or report their concerns compared to residents who were single, married or separated, although they were just as likely to have concerns.

Frequency of receiving visitors or the resident's number of children did not significantly affect the likelihood of residents sharing or reporting their concerns, nor did time living in the RACF. Whether the survey was completed by a proxy or by the resident also did not influence the likelihood of concerns being shared with others, although it should be noted that the proxy sample was small.

3.9 Resolution of official complaints

Of the main concerns that were officially reported, two-thirds were not resolved to residents' satisfaction. Smaller RACFs (0-60 beds) showed lower proportions of satisfactory complaint resolution compared to the other facility sizes (19.8% of all official complaints in this facility size were resolved; $p < 0.001$), but did not significantly differ between RACFs with 61-100 and >100 beds (29.2% and 28.8%) (Figure 15).

Complaints were significantly more likely to have been resolved for residents living in government-run RACFs (45.0% of all official complaints in this organisation type were resolved) compared to for-profit and non-profit RACFs (25.1% and 28.8%; $p < 0.001$; Figure 16). No difference in proportion of resolved complaints was observed between for-profit and non-profit RACFs ($p = 0.18$). Complaints were more likely to be resolved in metropolitan RACFs compared to regional ones ($p < 0.001$).

In more than half of the cases where residents felt the complaint was not resolved satisfactorily, the resident said nothing had changed (56.2%); as one resident put it, they were told 'not to go holding your breath about it'. In 6.6% of cases, the resident said there had been change but then things had gone back to the old way, while, in 4.9% of cases, the resident said the provider had done something but it was not enough. A relatively small proportion of residents said that they had experienced repercussions from making a complaint (2.6%); as noted earlier, fear of repercussions was a reason why a small share of concerns were not reported at all.

Though not a prompted response, 4.8% of residents said either understaffing or difficulties working in an aged care system were reasons that complaints were not resolved. Other free responses indicated that staff did not know how to resolve residents' concerns or that agency staff did not know who to pass complaints on to. Free responses are only available for a small proportion of the sample and may not be representative of the resident population.

The top unresolved official complaints (as a share of all unresolved official complaints) were:

1. Poor food and catering (13.9%)
2. Understaffed or not enough staff on duty (12%)
3. Staff not being adequately trained (6.9%)

Only concerns that represented more than 5.0% of unresolved complaints are listed above. See Table 22 in the Appendix for a full list of all official complaints and their rates of resolution.

Figure 15: Percentage of resolved complaints by facility size

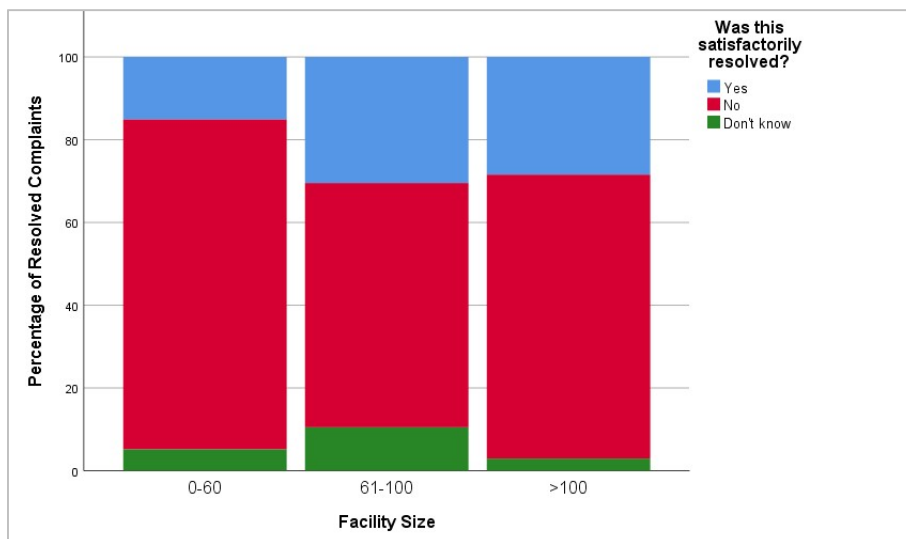
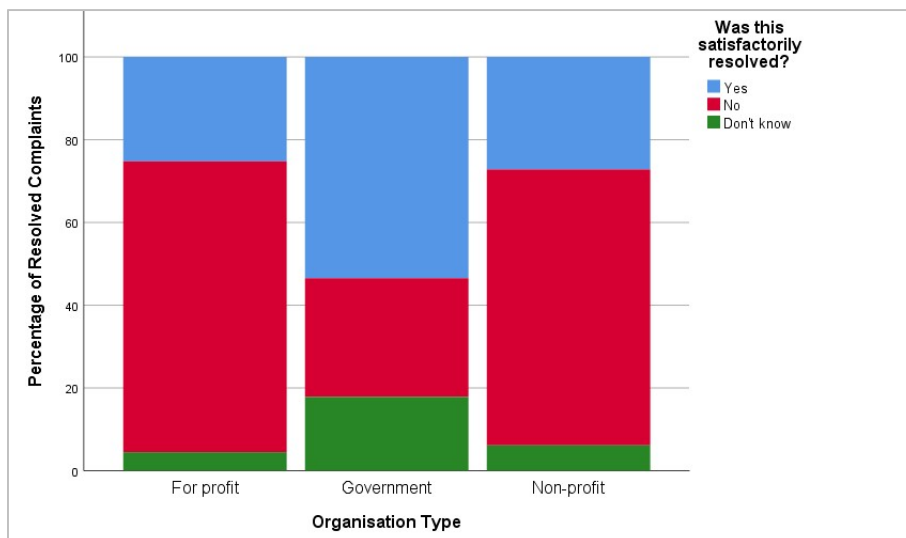


Figure 16: Percentage of resolved complaints by organisation type



The initial recipient of residents' complaints may influence the likelihood of satisfactory resolution. Speaking to doctors or to the aged care provider/head office resulted in two of the highest proportions of resolved complaints. While half of the concerns initially conveyed to agency staff were resolved, this finding must be interpreted with caution due to the low proportion of complaints that were reported to agency staff. It must also be noted that concerns could have multiple recipients and multiple drivers of complaint resolution.

Table 16: Proportion of concerns that were resolved based on the initial recipient of the complaint

Who resident spoke to about the concern	% of concerns that were resolved satisfactorily
Doctor	76.2
Agency staff	50.0
Aged care provider/head office	45.7
Aged care and facility staff	26.8
Health professionals	21.3
Family/friend	15.0
Volunteers	0.0
Police	0.0
Other residents	0.0

Table 17: Sharing, reporting and resolution of concerns by domain – aged care facility residents

Domain of concern	% of concerns in each domain that were shared with anyone	% of concerns in each domain that were officially reported		% of concerns in each domain officially reported that were resolved
		By resident	On behalf of resident*	
Room	62.3	86.9	0.0	17.8
Services and fees	59.5	74.3	27.2	30.6
Staff	52.8	69.0	8.7	16.4
Medical and health care	52.7	80.3	33.3	56.5
Facility	51.2	75.4	62.5	17.9
Choice	50.5	84.6	100.0	0.0
Personal care	37.0	85.3	0.0	44.1
Dignity and respect	34.0	54.4	40.0	89.1

* That client did not officially report themselves

Complaints in the domain of dignity and respect had the highest rate of satisfactory resolution (89.1% of complaints in this domain were resolved to residents' satisfaction). This was despite concerns about being treated with dignity and respect being least likely to be discussed with others or reported by residents as shown in Table 17. Specific information to ascertain why this was the case was not collected during this survey, but it may be that residents did not discuss concerns about being treated with dignity and respect unless those incidents were perceived to be 'serious enough' and, in response, RACFs were able to action resolutions to those concerns most of the time. Complaints in the domains of staff and choice had the lowest rates of satisfactory resolution (16.4% and 0.0%, respectively). This may reflect systemic drivers behind those concerns such that they are not able to be resolved easily. Similarly, concerns relating to the room and facility had low rates of satisfactory resolution (17.8% and 17.9%), which may also indicate the presence of some barriers to resolving residents' concerns in those areas.

The top official complaints resolved satisfactorily (as a share of all official complaints resolved satisfactorily) were:

1. Food and catering (17.6%)
2. Understaffed or not enough staff on duty (6.8%)
3. The way medication is managed (5.5%)
4. Call bell not being answered (5.5%)

Only those complaints that represented more than 5.0% of resolved complaints are listed above. See Appendix Table 22 for a full list. Looking at individual complaints across all domains, the greatest proportion of official complaints that were resolved related to the food and catering (17.6% of all resolved complaints). Complaints regarding understaffing were next most likely to be resolved satisfactorily (6.8%). This finding is surprising given that understaffing is a persistent and prevalent issue in residential aged care services often driven by systemic issues and may be more complicated to resolve in comparison to concerns about the way medication is managed (5.5%) or call bells going unanswered (5.5%), for example. However, this survey did not collect information about the actions taken by RACFs to resolve complaints and it is therefore not known why residents felt those complaints were resolved to their satisfaction.

4 Discussion and implications

4.1 Quality of care

The Aged Care Quality Standards define a framework of core requirements for quality care and safety for people in aged care. The eight standards promote residents' dignity and choice, involvement in assessment and planning, appropriate personal care, clinical care, and other daily services and supports, in an enriched environment that is sufficiently staffed and with an appropriate feedback and complaints system. The results of the Quality of Care and CCI-6D questionnaires indicate that while there is a share of aged care residents whose care needs are always met, there is a large share whose needs are mostly met, and a significant minority whose needs are not met to a considerable extent. This is also the case for Home Care Package (HCP) clients, Commonwealth Home Support Programme (CHSP) respite clients and residential respite clients, as shown in our separate survey³⁴ (Table 18).

Table 18: Quality of Care – overall results by care type

Care type	% of clients answering in all areas [#]		
	'always' in all areas	at least 'mostly' in all areas*	'sometimes' or less in any area
HCP clients	23.4	32.5	44.1
CHSP respite clients	14.1	35.2	50.7
Residential respite clients	26.9	27.4	45.7
Residential care clients	27.6	39.0	33.4

[#] Excludes responses to the complaints related domains since complaints are a response to unmet needs, excludes 'don't know' answers

* Excludes clients in the column "% 'always' in all domains so columns are all mutually exclusive and equate to 100% across the row

RACFs must strive for excellence in the quality of care they provide. If it is believed that RACFS should meet the needs of each resident all of the time, then nearly 75% of residents feel that some aspect of the quality of their care and service is failing them in one or more areas. If it is instead believed that RACFs should only be required to meet the needs of each resident most of the time, then around 33% of residents feel that some aspect of the quality of their care and service is failing them.

Residents' rating of quality of care as measured by the CCI-6D had an average score of 0.75 across the whole sample (where 1.0 indicates the best quality care). A recent study found an adjusted mean of 0.72 for residents with high levels of cognitive impairment living in Australian RACFs³⁵. Interestingly, in that study, a mean of 0.86 was reported for residents living in a clustered domestic model of care, and our study found similarly high levels of satisfaction amongst residents living in government-run RACFs. It should be noted that the previous study primarily used proxy report whereas our study used self-report, so the sample is somewhat dissimilar and the findings may not be comparable.

It is important to consider that responses given in this survey regarding quality of care may not be an accurate reflection of the actual quality of care being provided. As noted earlier, some long-term aged care residents may fear that complaining about their care could lead to undesirable social consequences³⁶. There is also some evidence to suggest that people report being satisfied with their health care regardless of their experiences of

³⁴ Batchelor et al., 2020

³⁵ Gnanamanickam et al., 2018

³⁶ Bomhoff & Friele, 2016

care, even if they have had negative experiences^{37,38}. This is especially relevant to older populations³⁹, who commonly experience social desirability pressures and therefore may be hesitant to express any concerns or displeasure about their services or care. The results of our residential care survey support this idea: although the majority of respondents answered 'always' to at least one item on the Quality of Care survey, the minority answered 'always' to all items; approximately two-thirds of the participants identified at least one or more areas of concern in the subsequent RFQ; and residents said they often did not make their concerns known for reasons including fear of repercussions and not wanting to be a nuisance.

A basic expectation from a human rights perspective is that all individuals be treated with respect and dignity at least most of the time, if not always. Nearly 7% of residents indicated that this was not the case. Furthermore, almost 8% of residents felt that they did not receive the support they need for their health and wellbeing at least most of the time. Almost 13% felt that they were unsupported in making decisions about the care and services they receive, and 16% felt that staff were not appropriately trained in providing such care and support. About 41% of residents were rarely or only sometimes satisfied with the amount of time staff spent with them. Inflexibility in staff care routines was noted by 44% of residents. These are concerns that a person-centred model of care is intended to address. However, person-centred models of care, while ideal, are difficult to consistently achieve in an under-resourced system and one motivated for profit.

In addition to requiring basic care and support, the social and psychological experiences and conditions for individuals living in RACFs are important. When asked about the living space, 49% of residents rarely or only sometimes felt 'at home' in the shared space of the facility and 36% rarely or only sometimes felt 'at home' in their own room. Nearly 12% could not access outside and gardens, and around 16% could only sometimes gain access. In the RFQ, the physical aspects of the facility and room were the least likely to be cited by 16.1% and 23.5% of residents respectively, with security, cleanliness, noise and privacy being the most common individual issues. Living in an aged care facility over the long term and not feeling at home can have adverse effects on residents' wellbeing. About 17% of residents felt that they lacked support to maintain their social connections, and 57% felt that they were rarely or only sometimes offered things to do that made them feel valued. In the RFQ only 6% of residents had concerns about lifestyle activities, which suggests that RACFs may be offering activities to keep residents busy, but those activities may not be meaningful for the resident and thus not reflecting person-centred care.

In our survey of Australian home and respite client's perspectives on care⁴⁰, HCP, CHSP respite, and residential respite clients responded similarly to people living in permanent residential care on the same quality of care measure. A high proportion of all groups felt positively about being treated with respect and dignity. Permanent residential clients were more likely to respond positively to the item measuring the extent to which they receive services and supports for daily living important for health and wellbeing. This may be reflective of the increased level of clinical and ongoing care provided in residential aged care, especially for those living there permanently, relative to care provided in the community.

4.2 Life satisfaction and quality

Aged care quality can be thought of as one factor affecting residents' life satisfaction and quality. Other positive and negative factors independent of care provision and its quality can also contribute to residents' life satisfaction and it is difficult to disentangle these effects.

³⁷ Russell et al., 2020

³⁸ Haggerty, 2010

³⁹ Mold et al., 2012

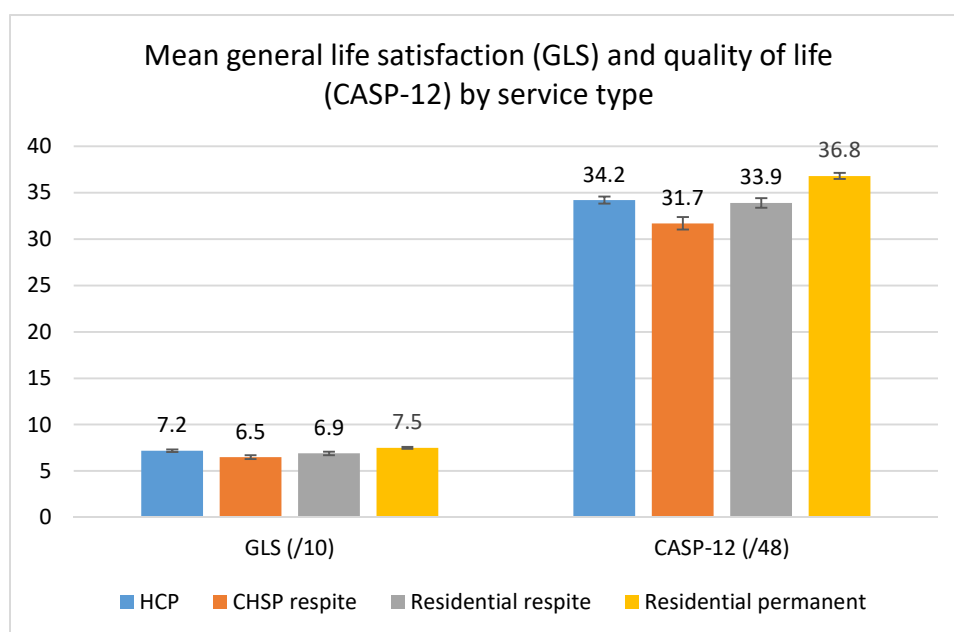
⁴⁰ Batchelor et al., 2020

Despite the problems with aged care service provision, residents rated their general life satisfaction as moderately high on average (GLS mean 7.5 out of 10, SD 2.3). This is comparable to life satisfaction as measured by a large longitudinal study in Europe (SHARE survey)⁴¹ of adults aged over 50 years who are primarily community-dwelling (mean 7.6 out of 10, SD 1.9), which was above the Australian average of 7.3 out of 10 reported by the OECD Better Life Index⁴². However, it was below the average score above 8 for adults aged over 65 in the HILDA study⁴³. The overall result in the general life satisfaction of RACF residents was influenced by the third of residents who rated very high life satisfaction. There was a significant share (16.9%) of residents that rated their life satisfaction low, at 5 or below on the 10-point scale.

When residents were asked to rate their quality of life in a number of different areas using the CASP-12, these areas were rated moderately positive on average (mean total score of 36.8 out of 48, SD 6.2), which was also comparable to the SHARE survey sample (mean total score of 36.7 out of 48, SD 6.5). Nonetheless, looking at the individual items within the CASP-12 we see a significant minority of residents feel constrained by their age, loss of control, left out of things, unable to do what they want, or lack a sense of meaning and being able to look forward to each day.

As shown in Figure 17, mean GLS score for permanent residents was higher than for HCP clients (mean 7.2), CHSP respite clients (mean 6.5), and residential respite clients (mean 6.6), as shown in our survey of Australian home and respite client's perspectives on care⁴⁴. The mean CASP-12 score was also slightly higher for permanent residents (mean 36.7) than for HCP (mean 34.2), CHSP respite (mean 31.7) and residential respite clients (mean 33.9). This may be due to the much higher proportion of proxy interviews in the home and respite care survey, as proxies are more likely to rate life satisfaction more negatively⁴⁵.

Figure 17: Life satisfaction and quality – HCP, CHSP respite, residential respite and residential permanent comparison



NB: Error bars represent 95% confidence interval

⁴¹ Survey of Health, Ageing and Retirement in Europe: <http://www.share-project.org/home0.html>

⁴² OECD, 2020

⁴³ Ambrey & Fleming, 2013

⁴⁴ Batchelor et al., 2020

⁴⁵ Trigg et al., 2011

4.3 Concerns

Two-thirds (66.8%) of residents cited at least one concern regarding their standard of care or living, with an average of 4 concerns per resident. The proportion of residents with concerns in each domain ranged from 16% (for the facility environment) to 46.7% (for staff). Representatives answering for the residents (of which there were only 24) also had widespread concerns, particularly regarding family-staff communication.

It is well-publicised that residential aged care staffing is a major issue in Australia. That was confirmed in our survey. One third of residents felt that their facilities were understaffed (34.3%), which is also reflected by unanswered call bells being one of the top concerns (16.6%). These concerns are in accordance with the literature considering work staff shortages, no minimum staffing levels, and aged care staff reports of an understaffed workforce⁴⁶. Lack of staff continuity was also evident with 15.1% of residents concerned about a high rate of staff turnover. This may be related to the concern that agency staff do not know residents and their needs (12.9%); residents may be uncomfortable with the lack of familiar faces and inability to develop consistent relationships with the care staff. Additionally, the quality of their care may be disrupted by staff members not being present long enough to become familiar with their needs and preferences.

Concerns about staff tie in with the high rates of concerns residents had in the dignity and respect (23.6%) and choice (17.5%) domains. The concerns raised included being treated like a child (7.5%) or shouted at by staff (2.9%), feeling forced to be dependent on staff (9.1%) or wear continence pads (4.4%), not having specific care needs thought about or listened to (7.6%), and choices about timing of meals (4.9%), personal care (3.9%), and having enough lifestyle activities (6.1%). It is also important to note that, while not a common concern, 3.0% of residents indicated being hurt or treated roughly by staff. Free-response answers and interviewer notes indicated that although the prevalence of abuse in the group of surveyed residents was very low (0.09%), these were cases of physical abuse. Other research suggests that the most prevalent form of elder abuse is psychological and is more likely to be recognised by staff than by residents themselves⁴⁷. Some instances of psychological abuse were indicated by the survey responses described above. Future research would be well-placed to examine rates of psychological abuse in residential aged care from the perspectives of residents and staff.

More than a quarter of residents had concerns about medical and health care (26.3%). The most common concerns related to aspects of falls and fall prevention (8.1%), medication management (7%) and access to medical professionals such as GPs, physios, podiatry, etc. (up to 5.2%). Similarly, residents had concerns about personal care provided (16.9%) such as how they are helped to shower (10%), groom (6.8%), use the toilet (5.9%), use continence aids (5.7%), or move around (5.6%).

Concerns about the facility and room environment, which were described in the previous section, were at a similar rate to medical/health care and personal care. A higher proportion of the sample was concerned about their room than the facility overall. Residential respite clients reported similar concerns regarding their room and the facility. Environmental factors have the potential to either substantially benefit or negatively impact people living in or accessing respite in aged care facilities and where the environment is substandard, design or refurbishment initiatives have the potential to maximise positive health outcomes for older people⁴⁸.

Finally, services and fees was among the most common areas of concern for residents (39.7%). This was largely related to food and catering or the dining experience (19.4% and 7.9% respectively), financial fees and charges (10.5%), and feeling lonely or bored (16%). Residents who said they were bored or lonely were less likely to have visitors daily or a few times a week, and more likely to have visitors once monthly or less often, compared

⁴⁶ Meagher et al., 2019; Productivity Commission, 2011

⁴⁷ Buzgova & Ivanova, 2011

⁴⁸ Neylon & Hill, 2019

to residents who did not say they were bored or lonely. Only 7.4% of residents reported having received visitors less than once a month or never. The majority of residents reported having visitors at least once a week (73.5%), with 47.3% having visitors at least a few times a week. This is consistent with responses to the Quality of Care questionnaire where 78.3% of residents said that they felt 'always' or 'mostly' supported in maintaining their social relationships and community connectedness. These results suggest that visitation is higher than suggested by the oft-quoted figure that 40% of residents in aged care never receive visitors⁴⁹.

In our survey of home and respite care clients, HCP, CHSP respite, and residential respite clients were all less likely to feel they were supported in maintaining their social relationships and community connections than permanent residents. It is likely that people living permanently in residential aged care feel more socially connected as they are co-located with other residents and surrounded daily by staff, which is often not the case for people living in the community. While the finding that most residents feel socially connected is a positive one, there is still a significant minority who do not feel this way (7% felt 'never' or 'rarely' and 38% felt 'sometimes' or 'mostly' supported to maintain social relationships). This finding, along with the finding that many residents feel lonely or bored or do not have access to sufficient lifestyle activities is in need of consideration. Having meaningful and cognitively stimulating activities are particularly important for a population of people with high prevalence of depression⁵⁰ and cognitive impairment⁵¹. Similarly, social isolation, boredom and loneliness have significant health implications⁵² and targeted interventions are required.

The concerns and their domains were similar for both permanent residents and residential respite clients⁵³. The most prevalent domains of concerns were very similar for both groups. Fees and services was one of the most common domains for both. Included in this domain are concerns about feeling lonely or bored, food, interesting lifestyle activities, and fees and charges. Staffing was the other most prevalent domain for both groups, although a higher percentage of permanent residents had concerns in this domain (46.7%) than residential respite clients (31%). Understaffing and the call bell not being answered were common concerns for both groups. For permanent residents, it is likely that these issues are more significant and noticeable because they are living permanently in the facility, whereas respite clients are only there for a relatively short period of time. Similarly, staff turnover would not be as noticeable for respite clients. This was reflected in the results: staff turnover was not a common concern for residential respite clients, but was a common concern for permanent residents. A relatively common concern reported by residential respite clients was, however, that 'agency staff do not know me and my needs', which relates to staff turnover. There is a clear lack of staffing in RACFs across Australia, especially in comparison to other international models of aged care⁵⁴. Shortages within the Australian aged care workforce mean that continuity of care for older people is lacking⁵⁵. Continuity of staff is an aspect of care that is extremely important for older people because not only do staff come to learn the preferences and needs of the people for whom they care, but they can also become a source of meaningful social contact. Understaffing means that agency staff (casual staff outsourced from other organisations) are relied upon to provide care in some RACFs. This reliance on agency staff is problematic, as it inhibits the delivery of person-centred care⁵⁶. It is also important to note that reliance on agency and casual

⁴⁹ Yaxley, 2017

⁵⁰ Australian Institute of Health and Welfare, 2013

⁵¹ Australian Institute of Health and Welfare, 2020

⁵² National Academies of Sciences, Engineering, and Medicine, 2020

⁵³ Australian perspectives on home and respite care, unpublished

⁵⁴ Eager, Westera & Kobel, 2020

⁵⁵ Royal Commission into Aged Care Quality and Safety, 2019

⁵⁶ Royal Commission into Aged Care Quality and Safety, 2019

staff who may work across multiple RACFs raises concerns regarding infection control in the context of the global COVID-19 pandemic.

4.4 Reporting and resolution of complaints

When residents were asked to list their top concerns (up to three), 34% said that they had none at all. This reflects that residents do not necessarily consider all of their concerns to be important. Of all the main concerns identified by residents, only 53.3% were reported or shared with others (i.e. became complaints). The primary reasons why these main concerns were not shared with others were because residents deemed them 'too minor' (40.4% of unshared concerns) or did not think anything would change (26.5%). This might reflect a number of factors, including resignation to their living conditions, low self-worth, power imbalances between staff and residents, and past experiences (e.g. learned helplessness). Some concerns that were not raised due to being 'too minor' included: being restrained (0.7%), being hurt or treated roughly by staff (0.8%), falls or falls prevention (0.8%), or being shouted at by staff (0.8%). The fact that concerns such as these were not shared with others at all raises a larger issue as to why such concerns are subjectively assessed as being 'too minor' by some residents when others would consider these to be clear examples of substandard care. As the factors influencing the number and type of concerns are multifaceted, so too are the reasons why residents decide to share or not to share their concerns and experiences with others.

Of the main concerns that residents did share with others, 74.7% were officially reported by the resident (to staff, management or head-office, none to the ACQSC) and 39.7% were unofficially reported (mainly to family and friends). Only nearly one quarter of the concerns unofficially shared with others were known to have then been officially reported on behalf of the resident (mainly to facility staff, only 1.8% to the ACQSC), while most (55.0%) were not. It appears that residents are often unaware of what happens after they discuss their concerns with other people, including agency staff and volunteers as this occurred in 21.9% of cases that were shared.

These findings demonstrate that existing public data about the prevalence and nature of officially-made complaints considerably underestimate the actual prevalence of concerns held by aged care residents. Appropriate action needs to be taken to improve the ability to identify and capture the concerns and complaints of residents in order to both gain understanding of key issues across the sector on a continuing and systematic basis, and to resolve issues for individual residents. This includes measures to empower residents, to encourage them to speak up about any concerns they might experience and to assure them that they have a right to quality of care at all times. As shown by responses to the Quality of Care questionnaire, nearly 18.0% of residents only sometimes or less often know how to make a complaint, or feel comfortable doing so. There needs to be a framework for people working in or with RACFs that provides guidance in how to respond to concerns being shared by residents. This should include clearly indicating to residents whether they will or will not be passing those concerns on and to whom. This appears to be especially important for transient staff such as agency staff or volunteers.

Aged care providers, and the system as a whole, also need to be more responsive to complaints that are made. Less than 70% of residents said they were confident that there would be appropriate action taken in response to a complaint most of the time or always. This lack of confidence may be justified given that the survey found 66% of official complaints were not resolved to the residents' satisfaction. For 56% of those complaints, residents reported that nothing had changed since the complaint was made, and almost 40% of complaints were still awaiting a satisfactory resolution.

Change is also needed to the ACQSC. While it is the aged care system regulator, it only becomes aware of, and involved in, a small proportion of concerns and complaints in the system. It is not known why residents and their families are not likely to report complaints to the ACQSC, but it may be that only the complaints deemed to be most serious or important are made to this body. It may also be considered a last resort if approaching

the RACF staff and/or management directly proves unsuccessful. However, the ACQSC focus is on accreditation standards and reporting obligations. This represents a minimal, rather than optimal, focus on quality⁵⁷. There is a need for a more comprehensive, integrated and system-level approach that promotes optimal quality, public accountability and continuous improvement. This may involve increased engagement with consumers through feedback mechanisms; developing more meaningful performance measures and collecting data that is made available to the public; encouraging and supporting service providers to engage in continuous improvement; and encouraging a culture of collecting and responding to feedback from staff, consumers and their families⁵⁸.

4.5 RACF type and size

This study found the average perspective of residents differed between facility types and sizes to a statistically significant extent. Results were consistently best for residents in government RACFs, and usually better for residents in non-profit RACFs than for-profit RACFs. As noted earlier in the report, comparisons for government RACFs should be considered indicative (rather than precise) due to the small number of government facilities in the sample, even though the comparisons passed statistical significance testing. Results by facility size were less consistent but overall there was a tendency for RACFs with 0-60 beds to have better resident perspectives than those with 61-100 or >100 beds.

- In the CCI-6D, residents' rated quality of care in government-run RACFs most highly (mean 0.9 out of 1) followed by non-profit (mean 0.8) and for-profit RACFs (mean 0.7). RACFs with 61-100 beds were rated significantly lower than those with 0-60 or >100 beds.
- General life satisfaction was rated most highly by residents living in government-run RACFs (mean 8.5 out of 10), followed by those living in non-profit RACFs (mean 7.9) and for-profit RACFs (mean 7.0). Residents in 0-60 bed RACFs rated their general life satisfaction significantly higher than those living in 61-100 beds and >100 beds RACFs (means 8.1, 7.4 and 7.5, respectively).
- Quality of life measured by the CASP-12 was highest for residents in government RACFs (mean 41.1), followed by non-profit (mean 38.14), and lowest in for-profit facilities (mean 34.8). RACFs with 0-60 beds had greater self-reported quality of life (mean 37.8) compared to those with 61-100 (mean 36.5) and >100 beds (mean 36.6).
- Government-run RACFs had the lowest proportion of residents with at least one concern (49.0%), followed by non-profit (60.2%) and for-profit RACFs (77.1%). The total number of concerns per resident was 69% lower in government-run RACFs than in for-profit RACFs, and 28% lower in non-profit RACFs than in for-profit RACFs. The rate of concerns was 50% higher in RACFs with 61-100 beds, and 16% higher in RACFs with >100 beds, compared to RACFs with less than 60 places.
- Government-run RACFs had the lowest number of main concerns per resident (mean 0.98), followed by non-profit (mean 1.41) and for-profits (mean 1.92). RACFs with 0-60 beds had a significantly lower number of main concerns (mean 1.31) compared to 61-100 bed RACFs (mean 1.74) and >100 bed RACFs (mean 1.70).
- For-profit RACFs showed the highest proportion of concerns being reported officially (85.0% of all complaints in this organisation type were reported officially), compared to non-profit (66.4%) and government (63.5%) RACFs, whereas government and non-profit RACFs had higher rates of unofficial reporting (36.5% and 46.2% of all complaints in each respective organisation type) compared to for-profits (32.5%). Official reporting was less likely to occur in RACFs with 0-60 beds (60.3% of all complaints in this facility size were reported officially) compared to those with 61-100 or >100 beds (71.5% and 83.0%). Facilities with 0-60 beds were also less likely to make unofficial complaints (33.0%

⁵⁷ Victorian Government, 2019

⁵⁸ Victorian Government, 2019

of all complaints in this facility size were made unofficially, compared to 40.6% for 61-100 beds and 42.0% for >100 beds).

- Complaints were significantly more likely to have been resolved for residents living in government-run RACFs compared to for-profit and non-profit RACFs. The proportion of complaints satisfactorily resolved was significantly smaller for RACFs with 0-60 beds (19.8% of all official complaints in this facility size were resolved) compared to both RACFs with 61-100 (29.2%) and >100 (28.8%) beds.

These results suggest that institutional factors play an important role in residents' experiences in care, noting there are likely to be a range of other un-measured factors that help further fully explain facility differences (e.g. management style, organisational culture, resident disposition). The aged care sector now operates in many senses the same way as any other commercial sector, which has been beneficial in some ways and counterproductive in other ways⁵⁹.

4.6 Looking to the future

Ultimately, everyone living in residential aged care has the right to quality of care. Although this study found that a proportion of residents are satisfied with the quality of their care, it is clear that a substantial proportion are not. These results highlight the need for action to improve quality of care delivered to those for whom the system is clearly failing to provide them with quality care and services in some or all areas.

To the best of our knowledge, this is the first survey of residential care in Australia to have quantitatively examined in detail how residents feel about their lives and the care they receive. These are the people inside the aged care system for whom the system is supposed to be designed, but whose interests and voices have too often been overlooked when decisions are made about the system. The next wave of reform to aged care will, we hope, correct that balance and optimise care quality.

It is clear that staffing issues, including understaffing, high staff turnover, and family-staff communication, are in need of addressing, as are many other aspects of residential aged care quality and services. This includes residents' social and emotional needs, as results revealed that many residents feel lonely or bored, do not feel socially connected, and do not feel that their needs are understood by their RACF. These results underscore the need for enhanced person-centred care in the aged care sector. The survey results also suggest the sector needs more effective management and regulation, including of how complaints are resolved and evaluating how the system is performing so problems are known and acted on earlier.

The survey results provide a benchmark by which efforts to improve the system and progress on promised reforms can be monitored honestly over time. It will be important to continue this work by establishing independent, transparent monitoring so reform of the aged care system is comprehensive, effective and lasting. We should not forget that the systematic problems in aged care were not widely acknowledged or given media attention until recently. Independent, transparent monitoring will help ensure public awareness is maintained, reforms are followed through, and history does not repeat.

⁵⁹ Davidson, 2018

5 Bibliography

Aged Care Quality and Safety Commission (2019a). *Aged Care Quality and Safety Commissions Annual Report 2018-19*. Australian Government: Canberra.

Aged Care Quality and Safety Commission (2019b). *What are Consumers Saying About Aged Care?*. Retrieved from <https://www.agedcarequality.gov.au/sites/default/files/media/AACQAConsumerExperienceReportTrends.pdf>

Aged Care Quality and Safety Commission (2020). *Making a Complaint*. Retrieved from <https://www.agedcarequality.gov.au/making-complaint>

Aka, P. C., Deason, L. M., & Hammond, A. (2011). Political Factors and Enforcement of the Nursing Home Regulatory Regime. *Journal of Law and Health*, 24(1), 1-44.

Akner, G. (2009). Analysis of multimorbidity in individual elderly nursing home residents. Development of a multimorbidity matrix. *Archives of Gerontology and Geriatrics*, 49(3), 413-419.

Ambrey, C. L., & Fleming, C. M. (2014). Life satisfaction in Australia: Evidence from ten years of the HILDA survey. *Social Indicators Research*, 115(2), 691-714.

Appleby, J., Devlin, N., & Parkin, D. (2016). *Using Patient Reported Outcomes To Improve Health Care*: Wiley Blackwell.

Aronson, J. (2006). Silenced complaints, suppressed expectations: The cumulative effects of home care rationing. *International Journal of Health Services* 36(3): 535-556.

Australian Institute of Health and Welfare. (2013). Depression in residential aged care 2008–2012. Aged care statistics series No. 39. Cat. no. AGE 73. Canberra: AIHW.

Australian Institute of Health and Welfare. (2019). *Services and places in aged care*. Retrieved from <https://www.gen-agedcaredata.gov.au/Topics/Services-and-places-in-aged-care>

Australian Institute of Health and Welfare. (2020). Australia's health 2020 data insights. Australia's health series no. 17. Cat. no. AUS 231. Canberra: AIHW.

Batchelor, F., Savvas, S., Peck, A., Dang, C., Wade, C., Goh, A. M.Y., Levinger, P., & Dow, B. (2020) *Inside the system: home and respite care clients' perspectives*. National Ageing Research Institute: Parkville, Victoria, Australia

Bomhoff, M., & Friele, R. (2018). Complaints in long-term care facilities for older persons: Why residents do not give 'free advice'. *Health Policy*(1), 75.

Borrat-Besson, C., Ryser, V.-A., & Goncalves, J. (2015). *An evaluation of the CASP-12 scale used in the Survey of Ageing and Retirement in Europe (SHARE) to measure Quality of Life among people aged 50+ (No.4)* FORS Working Paper Series.

Buzgova, R., & Ivanova, K. (2009). Elder abuse and mistreatment in residential settings. *Nursing Ethics*, 16(1), 110-126.

Buzgova, R., & Ivanova, K. (2011). Violation of ethical principles in institutional care for older people. *Nursing Ethics*, 18(1) 64-78.

Cooper, C., Selwood, A., & Livingston, G. (2008). The prevalence of elder abuse and neglect: a systematic review. *Age and Ageing*, 37(2), 151-160.

Courtney, M., O'Reilly, M., Edwards, H., & Hassall, S. (2009). The relationship between clinical outcomes and quality of life for residents of aged care facilities. *Australian Journal of Advanced Nursing*, The, 26(4), 49.

- Davidson, B. (2018). The marketisation of aged care in Australia. In D. Cahill & P. Toner. (Eds.), *Wrong way: how privatisation and economic reform backfired* (pp. 101-116). Carlton, Victoria. Latrobe University Press.
- Edvardsson, D., Fetherstonhaugh, D., & Nay, R. (2010). Promoting a continuation of self and normality: person-centred care as described by people with dementia, their family members and aged care staff. *Journal of Clinical Nursing*, 19(17-18), 2611-2618.
- Fine, M., & Davidson, B. (2018). The marketization of care: Global challenges and national responses in Australia. *Current Sociology*, 66(4), 503-516.
- Gnanamanickam, E., Dyer, S., Milte, R., Liu, E., Ratcliffe, J., & Crotty, M. (2019). Clustered domestic model of residential care is associated with better consumer rated quality of care. *International Journal for Quality in Health Care*, 31(6), 419-425.
- Haggerty, J. L. (2010). Are measures of patient satisfaction hopelessly flawed?. *BMJ*. 2010;341(7777):790-791.
- Lachs, M. S., & Pillemer, K. A. (2015). Elder Abuse. *New England Journal of Medicine* 373(20), 1947-1956.
- Meagher, G., Cortis, N., Charlesworth, S., & Taylor, W. (2019). *Meeting The Social And Emotional Support Needs Of Older People Using Aged Care Services*. Sydney: Macquarie University, UNSW and RMIT University.
- Milte, R., Ratcliffe, J., Chen, G., & Crotty, M. (2018). What characteristics of nursing homes are most valued by consumers? A discrete choice experiment with residents and family members. *Value in Health*, 21(7), 843-849.
- Milte, R., Ratcliffe, J., Bradley, C., Shulver, W., Bilton, R and, & Crotty, M. (2017). *CCI-6D User Guide: Basic information on how to use the CCI-6D instrument*. Flinders University and NHMRC Cognitive Decline Partnership Centre, Adelaide, South Australia.
- Mold, J. W., Lawler, F., Schauf, K. J., & Aspy, C. B. (2012). Does patient assessment of the quality of the primary care they receive predict subsequent outcomes?: An Oklahoma Physicians Resource/Research Network (OKPRN) Study. *The Journal of the American Board of Family Medicine*, 25(4), e1-e12.
- Natan, M. B., Lowenstein, A., & Eisikovits, Z. (2010). Psycho-social factors affecting elders' maltreatment in long-term care facilities. *International Nursing Review* (1), 113-120.
- Neylon, S., Bulsara, C., & Hill, A. M. (2019). Improving Australian Residential Aged Care Facilities: A Review of Minor Refurbishment Elements. *Journal of Housing For the Elderly*, 33(3), 227-243.
- OECD. (2020). *OECD Better Life Index – Australia*. Retrieved from <http://www.oecdbetterlifeindex.org/countries/australia/>
- Pérez-Rojo, G., Martín, N., Noriega, C., & López, J. (2018). Psychometric properties of the CASP-12 in a Spanish older community dwelling sample. *Aging & Mental Health*, 22(5), 700-708.
- Productivity Commission 2011. *Caring for Older Australians: Overview, Report No. 53, Final Inquiry Report, Canberra*. Retrieved from <https://www.pc.gov.au/inquiries/completed/aged-care/report>, May 5, 2020.
- Ratcliffe, J, Chen, G, Cleland, J, Kaambwa, B, Khadka, J, Hutchinson, C, Milte, R. (2020). *Australia's aged care system: assessing the views and preferences of the general public for quality of care and future funding*. Caring Futures Institute, Flinders University, South Australia. Retrieved from https://agedcare.royalcommission.gov.au/sites/default/files/2020-07/research_paper_6_-_australias_aged_care_system_-_assessing_the_views_an_.pdf
- Royal Commission into Aged Care Quality and Safety. (2019). *Interim Report: Neglect*. Retrieved from <https://agedcare.royalcommission.gov.au/publications/Documents/interim-report/interim-report-volume-1.pdf>
- Russell, S. J., Siostrom, K., Edwards, I. & Srikanth, V. (2020). Consumer experiences of home care packages. *Australasian Journal on Ageing*, 00, 1-8.

Survey of Health, Ageing and Retirement in Europe. (2017). *SHARE Wave 6 General Information*. Retrieved from https://www.share-datadocutool.org/question_constructs/view/4886

Victorian Government. (2019). *Royal Commission into Aged Care Quality and Safety: Submission by the Victorian Government*. Retrieved from <https://www.dhhs.vic.gov.au/publications/royal-commission-aged-care-quality-and-safety-submission-victorian-government>

Wells, Y., Brooke, E., & Solly, K. N. (2019). Quality and Safety in Aged Care Virtual Issue: What Australian research published in the Australasian Journal on Ageing tells us. *Australasian Journal on Ageing*(1), 1.

World Health Organization. (2017). *What is Quality of Care and Why is it Important?* Retrieved from https://www.who.int/maternal_child_adolescent/topics/quality-of-care/definition/en/ May 5, 2020

Yaxley, L. (2017). Up to 40 percent of aged care residents get no visitors, Minister Ken Wyatt says. Retrieved from <https://www.abc.net.au/news/2017-10-25/aged-care-residents-suffering-from-loneliness,-ken-wyatt-says/9085782>

6 Appendices

6.1 Questionnaires

This appendix provides detail on survey administration. Text in bold are the questions read out to survey respondents, and instructions in < > were for the survey administrator.

RESIDENT FEEDBACK QUESTIONNAIRE

RFQ A

Looking at this card can you tell me how often you feel this way?

<use SHOWCARD A, read each statement below>

	Never	Rarely	Sometimes	Mostly	Always	Don't Know
I am treated with respect and dignity						
I am supported to make my own decisions about the care and services I receive						
I receive care and support from aged care staff who have the appropriate skills and training						
I receive services and support for daily living that are important for my health and wellbeing						
I am supported to maintain my social relationships and connections with the community						
I know how to lodge a complaint						
I am comfortable lodging complaints						
I am confident that appropriate action will be taken when I make a complaint						

Now I am going to ask you about any concerns or complaints you might have about living here. I am going to ask about a lot of different areas and aspects of care and will get you to tell me “yes” or “no” if you have had any concerns or complaints about any of those things.

INTERVIEWER NOTE: *Response options provided on show cards. Try to direct them to say “yes” or “no” to each item, and try to direct them back to the card and obtain an answer if needed.*

RFQ B 1

In the last six months, have you had any concerns or complaints about not being treated with dignity and respect?

This might include:

	YES	NO	N/A	Refuse
Feeling forced to be dependent on staff				
Being treated like a child				
Being forced to wear continence pads				
Being shouted at by staff				
Not having your specific care needs thought about or listened to				
Or any other concerns about dignity and respect? [please specify]				

RFQ B 2

In the last six months, have you had any concerns or complaints about your personal care?

This might include:

	YES	NO	N/A	Refuse
How you are helped to shower				
How you are helped with eating				
How you are helped to use to the toilet				
How you are helped to get around				
How you are helped with personal grooming, like cutting nails or shaving				
How you are helped with continence aids – for example, being changed when they need to be, given enough supplies, or quality of supplies				
Or any other concerns about personal care? [please specify]				

RFQ B 3

In the last six months, have you had any concerns or complaints about medical and health care?

This might include:

	YES	NO	N/A	Refuse
Seeing a GP when needed				
Seeing a dentist when needed				
Accessing mental health services				
Quality of mental health services				
Accessing allied health services (e.g. physio, podiatry etc.)				
Quality of allied health services (e.g. physio, podiatry etc.)				
The way your medication is managed				
How any wounds have been looked after				
How catheters are used				
How pain is managed				
Falls or fall prevention				
Being restrained				
Or any other concerns about medical and health care? [please specify]				

RFQ B 4

In the last six months, have you had any concerns or complaints about the choices available to you?

This might include:

	YES	NO	N/A	Refuse
Not being allowed out of bed/chair/room, or not being allowed outside				
Choices about how and when you interact with other residents				
Choices about how and when you receive visitors				
Choices about personal care, like choosing when to shower				
Choices around the timing of meals				
Having enough lifestyle activities to choose from				
Or any other concerns about choice? [please specify]				

RFQ B 5

In the last six months, have you had any concerns or complaints about the staff?

This might include

	YES	NO	N/A	Refuse
Staff body language or attitude, like staff being unkind, rude, or unhappy				
Staff conduct				
Staff culture or facility culture (how staff work together or treat each other)				
High rate of staff turnover, or don't see many familiar faces				
Staff not being adequately trained				
Staff name badge/role not being displayed				
Concerns about communication between staff, such as poor handover between shifts				
Staff not being culturally sensitive (caring about my beliefs, values, spirituality, customs or religion)				
Call bell not being answered				
Being hurt or treated roughly by staff				
Understaffed or not enough staff on duty				
Agency staff do not know me and my needs				
Or any other concerns about staff? [please specify]				

RFQ B 6

In the last six months, have you had any concerns or complaints about your room?

This might include:

	YES	NO	N/A	Refuse
Feeling safe in your room				
The security of your room and possessions				
Cleanliness and maintenance of your room and bathroom				
Noise				
The privacy of your room				
Having space for visitors				
Or any other concerns about your room? [please specify]				

RFQ B 7

In the last six months, have you had any concerns or complaints about the facility? This means the common areas like the dining room, lounge and garden.

This might include:

	YES	NO	N/A	Refuse
The overall appearance of the facility				
The cleaning and maintenance of equipment, furniture and gardens				
Noise levels in the facility				
Safety of the facility				
Or any other concerns about the facility? [please specify]				

RFQ B 8

In the last six months, have you had any concerns or complaints about the services? For example, the food, laundry, lifestyle activities or the cost of being here.

This might include:

	YES	NO	N/A	Refuse
Food & catering				
Dining experience				
Social engagement with the community				
Feeling lonely or bored				
Access and reliability of internet/WIFI				
Quality of laundry services				
Having interesting lifestyle activities				
Fees and charges (increasing or many additional costs/everything is an extra cost or confusing)				
Or any other concerns about services and fees? [please specify]				

[REVIEW all items answered “yes” from RFQ B1- RFQ B8 to select up to 3 items]

These are all the items you indicated that are concerns for you about living at this facility <read out all items answered “yes” above>. **Which 3 of these items are your main concerns?**

01	
02	
03	

INTERVIEWER NOTE: *If participant endorses < 3 items, select all available.*

SECTION 3: REPORTING OF CONCERNS

Now, I’m going to ask you about whether you talked to anyone about these concerns or complaints and whether you made a formal complaint or not.

Have you talked to anyone about

	[read out the 3 main concerns]	YES	NO	Don’t know
01				
02				
03				

IF NO TO ANY ITEMS ABOVE: Why did you not talk to anyone about this?

	[read out the concerns answered “no” above]	[enter numbers (1-11) for each - interviewer to code unprompted]
01		
02		
03		

1. Too minor
2. Did not have access to phone/internet
3. Fear of repercussions
4. Did not think anything would change
5. Too difficult
6. Did not know how
7. Could not be bothered
8. Wasn’t sure who to report to
9. Did not want to be a nuisance (make a fuss)
10. Talked to friend/family member
11. Other (free text field)

IF YES TO ANY ITEMS ABOVE: Who did you talk to about it?

	[read out the concerns answered “yes” above]	[enter numbers (1-10) for each - interviewer to code unprompted]
01		
02		
03		

1. Aged care staff e.g. Manager, Carer, PCA, Nurse, Lifestyle Coordinator
2. Aged care provider/head office
3. Aged Care Quality and Safety Commission
4. Family/friend
5. Doctor
6. Agency staff
7. Volunteers
8. Aged care advocate
9. Health professionals
10. Other (free text):

Did they report the concern or complaint to anyone on your behalf?

	[read out the concerns answered “yes” above – only if did not answer 1-3 for the previous question]	YES	NO	Don’t know
01				
02				
03				

FOR ITEMS ANSWERED YES: Who did they report it to?

	[read out the concerns answered “yes” above]	[enter numbers (1-4) for each - interviewer to code unprompted]
01		
02		
03		

1. Aged care staff e.g. Manager, PCA, Nurse, Lifestyle Coordinator
2. Aged care provider/head office
3. Aged Care Quality and Safety Commission
4. Don’t know

FOR ITEMS ANSWERED NO: Why not?

	[read out the concerns answered “no” above]	[enter numbers (1-10) for each - interviewer to code unprompted]
01		
02		
03		

1. Too minor
2. Did not have access to phone/internet
3. Fear of repercussions
4. Did not think anything would change
5. Too difficult
6. Did not know how
7. Could not be bothered
8. Wasn't sure who to report to
9. Did not want to be a nuisance (make a fuss)
10. Other (free text field)

Was this concern or complaint resolved to your satisfaction?

	[read out the 3 main concerns from page 9]	YES	NO	Don't know
01				
02				
03				

IF NO: Why was this not resolved in a satisfactory way?

	[read out the concerns answered “no” above]	[enter numbers (1-9) for each - interviewer to code unprompted]
01		
02		
03		

1. No explanation
2. No apology
3. Still waiting for resolution
4. Nothing changed
5. The provider did something but not enough
6. At first things changed but then they went back to the old way
7. I experienced repercussions (e.g. poor treatment from staff etc.)
8. Don't know
9. Other (free text):

I am now going to ask you a number of questions about what it is like living here.

1 - How much time are caregiving staff able to spend with me (or my family member)?

- Care staff are always able to spend enough time attending to my individual needs
- Care staff are sometimes able to spend enough time attending to my individual needs
- Care staff are rarely able to spend enough time attending to my individual needs

2 - Do the shared spaces of the aged care home as a whole make you (or your family member) feel 'at home'?

- I feel very at home here
- I feel at home here sometimes
- I feel at home here rarely

3 - Does your own room here make you (or your family member) feel 'at home'?

- I feel very at home in my room
- I feel at home in my room sometimes
- I feel at home in my room rarely

4 - Is there access to outside and gardens in this aged care home?

- I can get outside whenever I want
- I can get outside sometimes
- I cannot get outside easily

5 - How often does the facility offer me (or my family member) things to do that make me feel valued?

- I can do things that make me feel valued often
- I can sometimes do things that make me feel valued
- I can only rarely or occasionally do things that make me feel valued

6 - How flexible is the aged care home with the care routines (e.g. when you or your family member gets out of bed, shower, eat your meals)

- Care routines are very flexible. The aged care home is very happy to change the times they provide help if I require it
 - There is a little flexibility in the care routines. The aged care home sometimes changes the times they provide care if I ask for it
 - There is not much flexibility in the care routines. Care and assistance seems to occur when it most suits the aged care home
-

GLS

Now thinking about life in general.

If you are extremely satisfied give me a 10.

If you are extremely dissatisfied give me a 0.

If you feel in between or neutral give me a number between 0-10.

INTERVIEWER NOTE: *Point to the card as you talk. Use the traffic light colours to help explain. If they continue to answer (good / bad / don't like it etc) try to direct them back to the card and obtain a number if possible.*

SHOWCARD D



PREFER NOT TO SAY – I don't want to answer.

Read the question below:

<Enter number from the card, 0-10>	
How satisfied are you with your life in general?	

CASP-12 questionnaire

Now thinking about how you feel living here in this facility. For each statement can you tell me how often you feel that way using this card.

If the question is not applicable to you or you don't want to say just let me know.

SHOWCARD E

Often
Sometimes
Rarely
Never
Not applicable/Don't know
Prefer not to say

CASP1. My age prevents me from doing the things I would like to

Often
Sometimes
Rarely
Never
Not applicable/Don't know
Prefer not to say

CASP2. I feel that what happens to me is out of my control

Often
Sometimes
Rarely
Never
Not applicable/Don't know
Prefer not to say

CASP3. I feel left out of things

Often
Sometimes
Rarely
Never
Not applicable/Don't know
Prefer not to say

CASP4. I can do the things that I want to do

Often
Sometimes
Rarely
Never
Not applicable/Don't know
Prefer not to say

CASP5. Family responsibilities prevent me from doing what I want to do

Often
Sometimes
Rarely
Never
Not applicable/Don't know
Prefer not to say

CASP6. Shortage of money stops me from doing the things I want to do

Often
Sometimes
Rarely
Never
Not applicable/Don't know
Prefer not to say

CASP7. I look forward to each day

Often
Sometimes
Rarely
Never
Not applicable/Don't know
Prefer not to say

CASP8. I feel that my life has meaning

Often
Sometimes
Rarely
Never
Not applicable/Don't know
Prefer not to say

CASP9. On balance, I look back on my life with a sense of happiness

Often
Sometimes
Rarely
Never
Not applicable/Don't know
Prefer not to say

CASP10. I feel full of energy these days

Often
Sometimes
Rarely
Never
Not applicable/Don't know
Prefer not to say

CASP11. I feel that life is full of opportunities

Often
Sometimes
Rarely
Never
Not applicable/Don't know
Prefer not to say

CASP12. I feel that the future looks good for me

Often
Sometimes
Rarely
Never
Not applicable/Don't know
Prefer not to say

CLOSING QUESTIONS:

NPS1. Would you recommend this facility to your friends and family?

Yes
No

NPS2. What do you like best about living here?

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INTERVIEWER NOTE: DUTY OF CARE

This is the end of the interview, however don't leave until the resident is feeling in a good place, particularly if they have answered negatively to the last three sets of questions.

Suggestion find something positive to end on:

Ask about something in their room that they look like they cherish – could be a pot plant / picture / knitting etc.

If they had discussed something, they were happy about or liked in the facility during the interview, ask a few follow up questions. You mentioned...that you like the scrabble games / activities. What do you like about playing, who gets the biggest word scores etc.

They might just need a change of scenery. You said that they had a lovely coffee shop here, can you show me. And if mobile they might just go for a walk out with you etc.

6.2 Additional results

Table 19: Quality of Care responses – aged care facility residents

	Never	Rarely	Sometimes	Mostly	Always	Don't know
Treated with respect and dignity	0.2%	0.7%	5.9%	18.9%	74.3%	0.0%
Supported to make my own decisions about the care and services I receive	1.8%	2.8%	8.1%	31.5%	55.8%	0.0%
Receive care and support from aged care staff who have the appropriate skills and training	0.2%	1.7%	13.8%	27.8%	54.4%	2.0%
Receive services and support for daily living that are important for my health and wellbeing	0.3%	0.5%	7.1%	25.6%	64.8%	1.8%
Supported to maintain my social relationships and connections with the community	1.8%	5.4%	9.7%	28.1%	50.2%	4.8%
Know how to lodge a complaint	7.0%	4.6%	6.9%	19.3%	50.8%	11.4%
Comfortable lodging complaints	4.0%	3.6%	10.2%	24.5%	50.3%	7.4%
Confident that appropriate action will be taken when I make a complaint	3.2%	4.3%	16.0%	24.8%	43.7%	7.8%

Table 20: CASP-12 responses – aged care facility residents

CASP-12 Item	Response	%
My age prevents me from doing the things I would like to	Often	25.9
	Sometimes	37.5
	Rarely	9.4
	Never	20.6
	Not Applicable / Don't know	5.6
	Prefer not to say	1.0
I feel that what happens to me is out of my control	Often	20.9
	Sometimes	33.0
	Rarely	14.3
	Never	25.3
	Not Applicable / Don't know	4.8
	Prefer not to say	1.6
I feel left out of things	Often	8.2
	Sometimes	16.0
	Rarely	19.6
	Never	52.5
	Not Applicable / Don't know	2.8
	Prefer not to say	0.9

CASP-12 Item	Response	%
I can do the things that I want to do	Often	41.0
	Sometimes	29.4
	Rarely	14.2
	Never	11.1
	Not Applicable / Don't know	3.0
	Prefer not to say	1.3
Family responsibilities prevent me from doing what I want to do	Often	1.5
	Sometimes	6.0
	Rarely	9.9
	Never	70.9
	Not Applicable / Don't know	10.4
	Prefer not to say	1.3
Shortage of money stops me from doing the things I want to do	Often	7.1
	Sometimes	11.9
	Rarely	12.4
	Never	63.2
	Not Applicable / Don't know	5.2
	Prefer not to say	0.3
I look forward to each day	Often	51.0
	Sometimes	32.0
	Rarely	9.2
	Never	3.9
	Not Applicable / Don't know	3.2
	Prefer not to say	0.7
I feel that my life has meaning	Often	41.3
	Sometimes	36.3
	Rarely	9.3
	Never	6.6
	Not Applicable / Don't know	5.8
	Prefer not to say	0.7
On balance, I look back on my life with a sense of happiness	Often	66.9
	Sometimes	22.6
	Rarely	5.2
	Never	3.2
	Not Applicable / Don't know	1.4
	Prefer not to say	0.7
I feel full of energy these days	Often	15.1
	Sometimes	34.1
	Rarely	29.6
	Never	19.9
	Not Applicable / Don't know	1.0

CASP-12 Item	Response	%
I feel that life is full of opportunities	Prefer not to say	0.3
	Often	22.9
	Sometimes	27.3
	Rarely	24.5
	Never	18.0
	Not Applicable / Don't know	6.7
	Prefer not to say	0.6
I feel that the future looks good for me	Often	27.3
	Sometimes	33.8
	Rarely	16.6
	Never	14.6
	Not Applicable / Don't know	6.6
	Prefer not to say	1.1

Table 21: Concerns of aged care facility residents by organisation type and facility size

Domain	Concerns	% of total residents with this concern	% of residents in each organisation type			% of residents in each facility size		
			For-profit	Government	Non-profit	0-60	61-100	>100
Staff	Understaffed or not enough staff on duty	34.3	45.2	17.3	27.6	25	34.9	39.6
	Call bell not being answered	16.6	20.8	3.8	14.6	13.9	17.1	18
	High rate of staff turnover, or don't see many familiar faces	15.1	18.6	0	13.8	2.7	20.9	19.1
	Staff not being adequately trained	14.1	17.4	2.9	12.7	10.7	15.7	15.4
	Staff name badge/role not being displayed	14.1	18.5	13.5	10.8	9.8	11.1	18.3
	Agency staff do not know me and my needs	12.9	17.3	2.9	10.5	11.4	13.9	13.3
	Concerns about communication between staff, such as poor handover between shifts	8.5	9.3	0	8.6	9.5	11.2	6.3
	Staff body language or attitude, like staff being unkind, rude, or unhappy	7	10.4	1	5	5.3	5.5	8.9
	Other	6.2	8	1.9	5.2	11.5	3.9	4.4
	Staff conduct	4.7	5.8	7.7	3.6	6.3	6.4	2.7
	Being hurt or treated roughly by staff	3	3.6	0	2.9	5.6	2.9	1.5
	Staff not being culturally sensitive (caring about my beliefs, values, spirituality, customs or religion)	2.7	2.9	0	2.9	1	3.7	3.2
	Staff culture or facility culture (how staff work together or treat each other)	2.2	3	0	1.9	0	5.7	1.6
Services and fees	Food & catering	19.4	21.6	8.7	18.7	8.1	25.7	22.6
	Feeling lonely or bored	16	19.2	2.9	14.7	10.2	19.6	17.4
	Quality of laundry services	10.5	13.3	2.9	9.1	14.1	13.9	6.4
	Fees and charges (increasing or many additional costs/everything is an extra cost or confusing)	10.3	11.7	13.5	9	10.7	14.9	7.4
	Dining experience	7.9	8.7	1.9	7.9	3.6	8.5	10.3
	Having interesting lifestyle activities	6.1	4.1	1	8.1	4.8	10.3	4.6
	Other	3.9	6.4	1	2.2	5.3	3.7	3.2
	Social engagement with the community	2	0.6	1	3.2	0	4.1	2.1
	Access and reliability of internet/WIFI	1.9	2.3	0	1.8	1.7	1.1	2.5

Domain	Concerns	% of total residents with this concern	% of residents in each organisation type			% of residents in each facility size		
			For-profit	Government	Non-profit	0-60	61-100	>100
Medical and health care	Falls or fall prevention	8.1	7.6	0	9.2	8.8	15.2	3.8
	The way your medication is managed	7	7.6	0	7.2	7.1	9.1	5.7
	Seeing a GP when needed	5.2	4.7	12.5	5	3.9	10.2	3.3
	Seeing a dentist when needed	4.6	3	0	6.2	1	8.9	4.2
	How pain is managed	4.4	3.6	1	5.4	2.7	2.7	6.3
	Other	4.4	5.2	0	4.3	3.4	9.8	2
	Accessing allied health services (e.g. physio, podiatry etc.)	2.9	1.1	0	4.5	0.8	4.6	3.2
	Quality of allied health services (e.g. physio, podiatry etc.)	2.2	2.4	0	2.2	0	2.9	3.2
	How any wounds have been looked after	2	2.4	5.8	1.4	1.9	2.8	1.5
	Being restrained	1.5	0.6	5.8	1.9	1.9	1.1	1.6
	How catheters are used	1.2	1.7	0	0.9	1	1.8	1
	Quality of mental health services	1	1.7	1	0.4	0	2.7	0.6
	Accessing mental health services	0.8	0.6	1	0.9	0	1.8	0.6
Dignity and respect	Feeling forced to be dependent on staff	9.1	12.4	1	7.4	5.4	9.6	11
	Not having your specific care needs thought about or listened to	7.6	6.5	0	9.2	7.1	13.2	4.7
	Being treated like a child	7.5	9.3	1	6.7	8.7	5.5	7.9
	Being forced to wear continence pads	4.4	8.8	1	1.5	6.1	3	4.3
	Being shouted at by staff	2.9	2.4	6.7	3	2.7	6.4	1.1
	Other	2.7	3	0	2.7	2.5	3.7	2.1
Room	The security of your room and possessions	9.2	14.5	1	6	9.5	9.4	8.9
	Cleanliness and maintenance of your room and bathroom	9	10.4	5.8	8.3	7.3	10.5	9.2
	Noise	7.8	7.6	6.7	8.1	4.8	10.5	8.1
	The privacy of your room	5.7	7	1	5.1	2.7	8.6	5.8
	Feeling safe in your room	3.7	5	1	2.2	0.8	3.7	5.3
	Having space for visitors	3.3	3	1.9	3.7	1.7	6.8	2.2
	Other	3	3.4	5.8	2.4	7.1	4.1	0
Choice	Having enough lifestyle activities to choose from	6.1	5.3	11.5	6.3	5.6	10.5	4

Domain	Concerns	% of total residents with this concern	% of residents in each organisation type			% of residents in each facility size		
			For-profit	Government	Non-profit	0-60	61-100	>100
	Choices around the timing of meals	4.9	4.7	0	5.4	2.7	7.7	4.6
	Choices about how and when you interact with other residents	4.1	5.7	0	3.2	8.7	2.9	2
	Choices about personal care, like choosing when to shower	3.9	3.4	0	4.5	0	6.6	4.6
	Other	3	3.6	0	2.8	0.8	5.9	2.5
	Not being allowed out of bed/chair/room, or not being allowed outside	1.2	1.1	0	1.3	0	1.1	2
	Choices about how and when you receive visitors	1	1.1	0	1	1	0	1.6
Personal care	How you are helped to shower	10	15.2	0	7	10.5	13	7.9
	How you are helped with personal grooming, like cutting nails or shaving	6.8	10.5	0	4.6	7.1	8.2	5.8
	How you are helped to use to the toilet	5.9	7.1	1	5.4	1.9	8.2	6.9
	How you are helped with continence aids – for example, being changed when they need to be, given enough supplies, or quality of supplies	5.7	9.4	0	3.5	5.9	7.3	4.7
	How you are helped to get around	5.6	8.8	0	3.7	2.7	7.5	6.2
	Other	4.3	6.9	0	2.8	8.7	3.9	2
	How you are helped with eating	3.2	4.1	0	2.8	2.7	1.8	4.2
Facility	Noise levels in the facility	9.8	12.7	8.7	7.7	8.8	11.6	9.3
	The cleaning and maintenance of equipment, furniture and gardens	5.1	8.1	0	3.3	8	2	5.1
	Other	3.6	6.3	0	1.9	7.6	2.9	1.5
	Safety of the facility	2.7	3	1	2.7	0.8	3.9	3.1
	The overall appearance of the facility	1.9	3.6	0	0.9	1.7	1.8	2

Table 22: Main concerns, complaints and resolutions – aged care facility residents

Main concerns	Unreported main concerns		Complaints		Resolution of official complaints		
	Rate* (%)	Share of all concerns not reported (%)	Rate^ (%)	Share of all complaints (%)	Rate not satisfactorily resolved# (%)	Share of all unresolved complaints (%)	Share of all satisfactory resolutions (%)
Feeling forced to be dependent on staff	58.9	1.4	41.1	0.9	0.0	0.0	4.0
Being treated like a child	63.5	1.7	36.5	0.9	0.0	0.0	1.3
Being forced to wear continence pads	67.8	1.3	32.2	0.6	0.0	0.0	2.7
Being shouted at by staff	77.6	1.0	22.4	0.3	0.0	0.0	1.3
Not having your specific care needs thought about or listened to	83.6	1.6	16.4	0.3	0.0	0.0	0.0
Other concerns about dignity and respect	49.8	1.0	50.2	0.9	47.8	0.5	1.5
How you are helped to shower	56.6	3.0	43.4	2.0	49.4	1.6	4.2
How you are helped with eating	100.0	0.3	0.0	0.0	0.0	0.0	0.0
How you are helped to use to the toilet	56.0	2.0	44.0	1.4	19.2	0.5	3.9
How you are helped to get around	88.9	2.6	11.1	0.3	0.0	0.0	1.3
How you are helped with personal grooming, like cutting nails or shaving	76.3	2.2	23.7	0.6	100.0	1.2	0.0
How you are helped with continence aids	40.9	0.6	59.1	0.8	100.0	1.0	0.0
Other concerns about personal care	41.9	0.7	58.1	0.9	33.1	0.5	1.3
Seeing a GP when needed	48.1	1.3	51.9	1.2	36.2	0.6	2.7
Seeing a dentist when needed	50.5	1.0	49.5	0.9	46.0	0.5	1.5
Accessing mental health services	100.0	0.1	0.0	0.0	0.0	0.0	0.0
Quality of mental health services	100.0	0.1	0.0	0.0	0.0	0.0	0.0
Accessing allied health services (e.g. physio, podiatry etc.)	50.9	0.6	49.1	0.5	50.0	0.5	1.3
The way your medication is managed	10.5	0.3	89.5	2.3	41.6	1.6	5.5
How any wounds have been looked after	55.0	0.4	45.0	0.3	0.0	0.0	1.3
How catheters are used	0.0	0.0	100.0	0.3	100.0	0.6	0.0

Main concerns	Unreported main concerns		Complaints		Resolution of official complaints		
	Rate* (%)	Share of all concerns not reported (%)	Rate^ (%)	Share of all complaints (%)	Rate not satisfactorily resolved# (%)	Share of all unresolved complaints (%)	Share of all satisfactory resolutions (%)
How your pain is managed	16.0	0.4	84.0	1.7	81.7	2.6	1.5
Falls or fall prevention	66.3	1.9	33.7	0.9	30.8	0.5	2.8
Being restrained	100.0	0.3	0.0	0.0	0.0	0.0	0.0
Other concerns about medical and health care	78.0	2.5	22.0	0.6	0.0	0.0	2.9
Not being allowed out of your bed/chair/room, or not being allowed outside	0.0	0.0	100.0	0.3	100.0	0.6	0.0
Choices about how and when you interact with other residents	48.8	0.6	51.2	0.6	100.0	1.1	0.0
Choices about how and when you receive visitors	100.0	0.7	0.0	0.0	0.0	0.0	0.0
Choices about your personal care, like choosing when to shower	44.9	1.3	55.1	1.4	100.0	2.6	0.0
Choices around the timing of your meals	64.1	1.6	35.9	0.8	100.0	1.0	0.0
Having enough lifestyle activities to choose from	51.0	1.3	49.0	1.2	72.1	1.6	0.0
Other concerns about choice	30.3	0.7	69.7	1.4	100.0	2.7	0.0
Staff body language or attitude, like staff being unkind, rude, or unhappy	49.8	1.7	50.2	1.5	60.3	1.7	2.8
Staff culture or facility culture (how staff work together or treat each other)	100.0	0.3	0.0	0.0	0.0	0.0	0.0
High rate of staff turnover, or you don't see many familiar faces	81.4	5.5	18.6	1.1	68.2	1.1	1.3
Staff not being adequately trained	21.6	1.9	78.4	6.3	72.2	6.9	1.3
Staff name badge/role not being displayed	59.8	3.0	40.2	1.8	53.1	1.2	1.3
Concerns about communication between staff, such as poor handover between shifts	44.0	1.3	56.0	1.5	100.0	1.0	0.0
Your call bell not being answered	35.8	2.9	64.2	4.7	57.6	4.4	5.5

Main concerns	Unreported main concerns		Complaints		Resolution of official complaints		
	Rate* (%)	Share of all concerns not reported (%)	Rate^ (%)	Share of all complaints (%)	Rate not satisfactorily resolved# (%)	Share of all unresolved complaints (%)	Share of all satisfactory resolutions (%)
Being hurt or treated roughly by staff	50.0	0.7	50.0	0.6	100.0	1.1	0.0
Understaffed or not enough staff on duty	51.3	14.5	48.7	12.4	76.6	12.0	6.8
Agency staff do not know me and my needs	65.7	2.6	34.3	1.2	52.2	0.6	0.0
Other concerns about staff	1.6	0.1	98.4	3.5	89.2	4.8	0.0
Feeling safe in your room	23.1	0.3	76.9	0.9	50.0	0.5	1.3
The security of your room and possessions	30.7	1.6	63.5	2.9	89.1	4.3	1.3
Cleanliness and maintenance of your room and bathroom	0.0	0.0	100.0	2.3	100.0	3.7	0.0
Noise	20.8	0.7	79.2	2.3	73.5	2.7	2.5
The privacy of your room	83.8	1.7	16.2	0.3	100.0	0.5	0.0
Having space for visitors	100.0	0.4	0.0	0.0	0.0	0.0	0.0
Other concerns about the room	65.7	1.4	34.3	0.6	49.0	0.6	1.5
The cleaning and maintenance of equipment, furniture and gardens	0.0	0.0	100.0	0.3	100.0	0.5	0.0
Noise levels in the facility	58.6	3.3	41.4	2.1	100.0	3.3	0.0
Safety of the facility	6.8	0.1	93.2	0.8	33.3	0.5	2.5
Other concerns about the facility	51.8	0.3	48.2	0.3	100.0	0.5	0.0
Food and catering	26.4	5.5	73.6	13.8	63.4	13.9	17.6
Dining experience	46.4	1.3	53.6	1.3	80.0	2.0	1.3
Social engagement with the community	0.0	0.0	100.0	0.3	0.0	0.0	1.3
Feeling lonely or bored	68.4	8.9	31.6	3.7	55.1	2.0	4.2
Quality of laundry services	30.3	1.8	69.7	3.7	75.0	4.8	4.1
Having interesting lifestyle activities	33.6	1.0	66.4	1.7	80.9	2.1	1.3

* Main concerns unreported (not discussed with others), as a share of all main concerns of that type (reported and unreported)

^ Main concerns reported, as a share of all main concerns of that type (reported and unreported)

Main concerns reported officially that were not satisfactorily resolved, as a share of all main concerns officially reported of that type

Table 23: Most common reasons why residents did not discuss or report their main concerns

Main concern	Share of all main concerns not discussed or reported (%)	Share of main concerns not discussed or reported because residents thought they were too minor (%)	Share of main concerns not discussed or reported because residents thought nothing would change (%)	Share of main concerns not discussed or reported because residents did not want to be a nuisance (%)
Understaffed or not enough staff on duty	14.5	7.1	22.8	25.7
Feeling lonely or bored	8.9	9.8	13.4	6.1
Food and catering	5.5	4.8	6.1	10.6
High rate of staff turnover, or you don't see many familiar faces	5.5	7.8	8.5	11.8
Noise levels in the facility	3.3	3.9	4.7	0.4
How you are helped to shower	3.0	5.7	1.3	0.0
Staff name badge/role not being displayed	3.0	4.8	1.3	0.0
Your call bell not being answered	2.9	1.7	7.2	9.8
Fees and charges	2.7	1.5	2.8	2.2
Agency staff do not know me and my needs	2.6	2.3	5.0	4.1
How you are helped to get around	2.6	4.8	1.2	0.0
Other concerns about medical and health care	2.5	3.1	4.7	0.0
How you are helped with personal grooming, like cutting nails or shaving	2.2	2.4	1.3	1.8
How you are helped to use to the toilet	2.0	3.2	0.0	0.0
Staff not being adequately trained	1.9	0.0	1.1	2.2
Falls or fall prevention	1.9	0.9	0.0	0.0
Quality of laundry services	1.8	1.2	0.0	0.0
Being treated like a child	1.7	0.7	2.6	2.4
Staff body language or attitude, like staff being unkind, rude, or unhappy	1.7	1.7	1.3	2.0
The privacy of your room	1.7	1.6	1.2	0.0

Main concern	Share of all main concerns not discussed or reported (%)	Share of main concerns not discussed or reported because residents thought they were too minor (%)	Share of main concerns not discussed or reported because residents thought nothing would change (%)	Share of main concerns not discussed or reported because residents did not want to be a nuisance (%)
Choices around the timing of your meals	1.6	2.4	1.3	0.0
Not having your specific care needs thought about or listened to	1.6	3.3	2.4	0.0
The security of your room and possessions	1.6	0.0	0.0	2.2
Feeling forced to be dependent on staff	1.4	1.7	1.3	2.0
Other concerns about the room	1.4	1.7	0.0	0.0
Having enough lifestyle activities to choose from	1.3	1.7	0.0	0.0
Being forced to wear continence pads	1.3	1.7	0.0	0.0
Choices about your personal care, like choosing when to shower	1.3	0.7	2.6	0.0
Concerns about communication between staff, such as poor handover between shifts	1.3	0.0	1.1	2.0
Dining experience	1.3	1.7	1.2	0.0
Seeing a GP when needed	1.3	1.5	1.3	1.8
Being shouted at by staff	1.0	0.9	0.0	4.2
Seeing a dentist when needed	1.0	1.7	0.0	0.0
Having interesting lifestyle activities	1.0	1.7	0.0	0.0
Other concerns about dignity and respect	1.0	1.6	1.2	0.0
Other concerns about choice	0.7	0.0	0.0	0.0
Other concerns about personal care	0.7	0.0	0.0	0.0
Choices about how and when you receive visitors	0.7	0.8	0.0	2.2
Being hurt or treated roughly by staff	0.7	0.9	0.0	2.0
Noise	0.7	0.9	0.0	0.0

Main concern	Share of all main concerns not discussed or reported (%)	Share of main concerns not discussed or reported because residents thought they were too minor (%)	Share of main concerns not discussed or reported because residents thought nothing would change (%)	Share of main concerns not discussed or reported because residents did not want to be a nuisance (%)
How you are helped with continence aids	0.6	1.5	0.0	0.0
Choices about how and when you interact with other residents	0.6	1.5	0.0	0.0
Accessing allied health services (e.g. physio, podiatry etc.)	0.6	1.5	0.0	0.0
How any wounds have been looked after	0.4	0.0	0.0	2.2
How your pain is managed	0.4	0.2	0.0	0.0
Having space for visitors	0.4	0.2	1.1	0.0
How you are helped with eating	0.3	0.0	0.0	0.0
Other concerns about the facility	0.3	0.0	0.0	2.0
Other concerns about services and fees	0.3	0.0	0.0	0.0
Staff culture or facility culture (how staff work together or treat each other)	0.3	0.0	0.0	0.0
The way your medication is managed	0.3	0.0	0.0	0.0
Feeling safe in your room	0.3	0.7	0.0	0.0
Being restrained	0.3	0.7	0.0	0.0
Other concerns about staff	0.1	0.0	0.0	0.4
Safety of the facility	0.1	0.0	0.0	0.0
Accessing mental health services	0.1	0.0	0.0	0.0
Quality of mental health services	0.1	0.2	0.0	0.0
Cleanliness and maintenance of your room and bathroom	0.0	0.0	0.0	0.0
How catheters are used	0.0	0.0	0.0	0.0
Not being allowed out of your bed/chair/room, or not being allowed outside	0.0	0.0	0.0	0.0

Main concern	Share of all main concerns not discussed or reported (%)	Share of main concerns not discussed or reported because residents thought they were too minor (%)	Share of main concerns not discussed or reported because residents thought nothing would change (%)	Share of main concerns not discussed or reported because residents did not want to be a nuisance (%)
The cleaning and maintenance of equipment, furniture and gardens	0.0	0.0	0.0	0.0
Social engagement with the community	0.0	0.0	0.0	0.0