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into Aged Care Quality and Safety

INSIDE THE SYSTEM: HOME AND RESPITE CARE CLIENTS' PERSPECTIVES

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OCTOBER 2020

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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.

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Inside the system: home and respite care clients' perspectives

Report for the Royal Commission into
Aged Care Quality and Safety

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October 2020

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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
ACQSC	Aged Care Quality and Safety Commission
ANOVA	Analysis of variance
CATI	Computer Assisted Telephone Interview
CASP-12	Control, Autonomy, Self-Realisation and Pleasure scale
CFQ	Client Feedback Questionnaire
CHSP	Commonwealth Home Support Programme
Carers	Family and unpaid carers
Care staff/care workers	Paid aged care workers
CDC	Consumer directed care
Client	Person accessing aged care services In this report 'client' and 'respondent' are used interchangeably and include respondents who are proxies, unless otherwise specified in the text
GLS	General life satisfaction
Ipsos	Ipsos Global Market Research
IQR	Interquartile range
HCP	Home Care Package
NARI	National Ageing Research Institute
Proxy	Person completing survey on behalf of aged care client
QoC	Quality of Care
RACF/s	Residential aged care facility/ies
Representative	Nominated representative of a person receiving care
Resident	Person accessing residential aged care services
Respite	Short-term care provided to give a carer a break
Royal Commission	Royal Commission into Aged Care Quality and Safety
SCRQoL	Social Care-Related Quality of Life
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 older people who receive home care or respite care services, 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 UNSW. The study complements a separate survey that was conducted to seek the views of people in residential aged care, covered in a separate report.¹

Design

In this survey, telephone interviews were conducted between mid-April 2020 and early June 2020 with a randomly drawn representative sample of clients or their representative who were receiving a Home Care Package (HCP), Commonwealth Home Support Programme (CHSP) respite services (in-home, centre, cottage or flexible respite), or residential respite services.

The sample consisted of 1,223 respondents, comprising 865 interviews with HCP clients across all four levels (from Level 1 for basic care needs to Level 4 for high care needs), 155 interviews with CHSP respite clients, and 203 interviews with residential respite clients. Almost half (49.8%) of respondents were client representatives (proxies) who answered on behalf of a client.

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 aged care population of Australia.

Quality of care

The results of the Quality of Care questionnaire indicate that while HCP, CHSP respite and residential respite groups all include a proportion of clients whose care needs are always met, there is a large proportion whose needs are mostly met, and a significant proportion who feel their needs are not met in one or more aspects of their care. If it is believed that the needs of people receiving aged care should be met all of the time, then around 77% of HCP clients, 86% of CHSP respite clients and 73% of residential respite clients feel that some aspect of the quality of their care and service is failing them. If it is instead believed that the needs of these people should be met at least most of the time, then around 44% of HCP clients, 51% of CHSP respite clients and 46% of residential respite clients feel that some aspect of the quality of their care and service is failing them.

In each of the care types there were similar shares of clients answering 'always' or 'mostly' to the individual domains of care. Around 90% said they were 'always' or 'mostly' treated with respect and dignity; 80% or more said the same about receiving care and support from appropriately trained aged care staff. Similarly, 82-85% responded 'always' or 'mostly' when asked if they receive the services and supports for daily living; and over 80% were 'always' or 'mostly' able to make their own decisions about care and services. All groups responded slightly less positively about the extent to which they feel supported to maintain social relationships and connections with the community (59-67% responded 'always' or 'mostly'). CHSP respite and

¹ Batchelor et al., 2020

residential respite clients were less likely to feel confident that action would be taken in response to a complaint (59-61% 'always' or 'mostly') than were HCP clients (73%). CHSP respite and residential respite clients were also less likely to report having knowledge about the complaints process and to feel comfortable in lodging complaints.

Life satisfaction and quality

The quality of aged care can affect residents' life satisfaction and quality. Despite the problems with aged care service provision, all client types provided moderately high average ratings for measures of life satisfaction, quality of life and social care-related quality of life. General life satisfaction averaged 7.2 out of 10 for the HCP clients (decreasing with increasing package level), 6.8 for residential respite and 6.5 for CHSP respite clients. On average, GLS was significantly lower when surveys were completed by proxies (client's nominated representative) than when the surveys were completed by clients themselves.

Quality of life as measured by the CASP-12 showed similar patterns within and between care types. Mean CASP-12 scores were 34.2 out of 48 for HCP clients (again decreasing with increasing HCP level), 33.7 for residential respite clients, and significantly lower at 31.7 for the CHSP respite clients.

Social care-related quality of life was also significantly lower for CHSP respite clients than for the HCP and residential respite clients (means 0.7, 0.8, 0.8 respectively where the maximum score is 1.0). As with the two previous measures, mean proxy scores were significantly lower than scores obtained when the survey was completed by clients.

Concerns and complaints

There was a high prevalence of concerns held by respondents in each service group: the average number of concerns for HCP clients was 4 (significantly increasing with HCP level); for CHSP respite clients it was 3.5; and for residential respite clients it was 4.4. Concerns were common in all domains of aged care and services. Figure A and Figure B show the most common domains of concern in each care type, including permanent residential care from our separate survey.

Figure A: Most common domains in which respondents identified concerns – HCP clients & CHSP respite clients

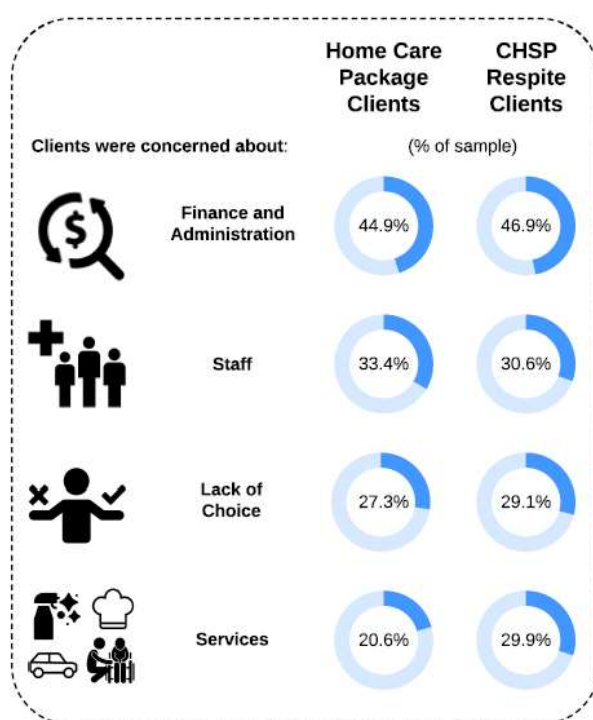
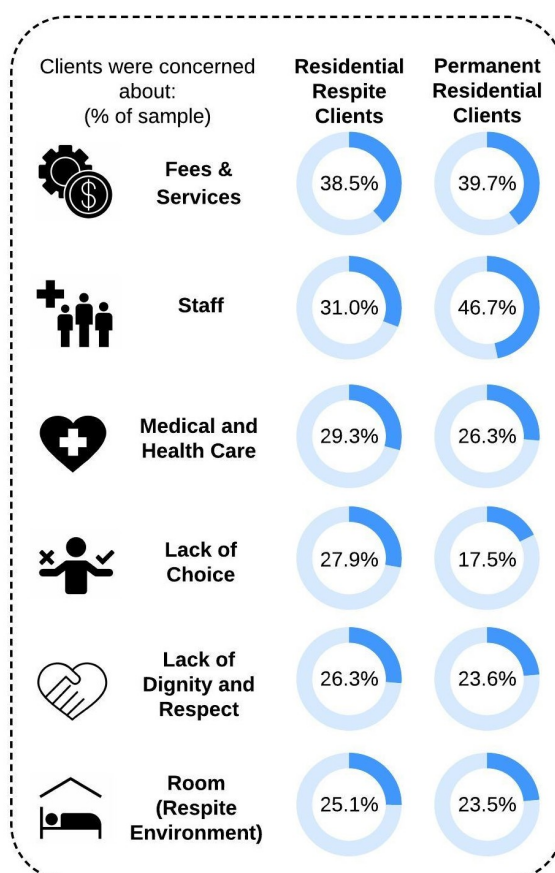
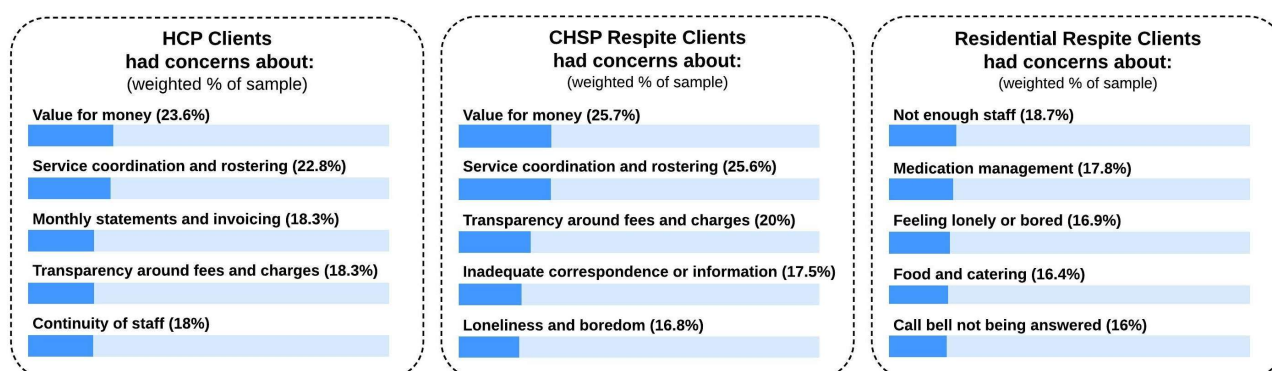


Figure B: Most common domains in which respondents identified concerns – Residential respite and permanent clients



Across domains, the five most common individual concerns for each care type are shown in Figure C and full details are contained in the body of the report.

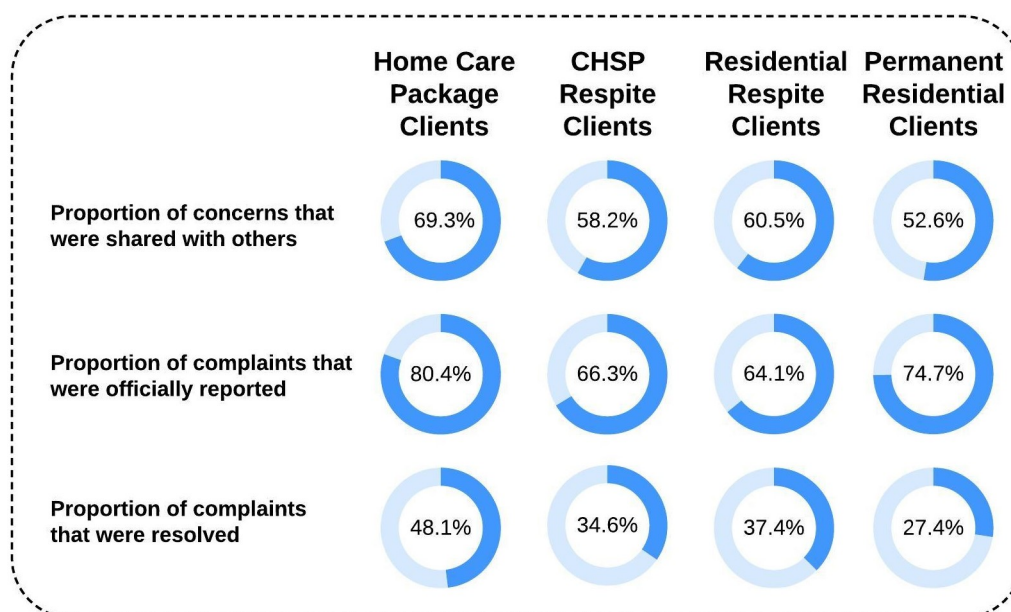
Figure C: Top five most common individual concerns (as a percentage of main concerns)



Respondents were asked whether they had shared their main concerns (up to three) with others. In HCP, less than 70% of the main concerns were shared with anyone, and this was even lower in CHSP and residential respite as shown in Figure D. The main reasons HCP clients did not report concerns were that they ‘did not think anything would change’ (17%), or the concern was ‘too minor’ (14%), or they ‘didn’t want to be a nuisance or make a fuss’ (14%). The most common reasons for not reporting concerns among CHSP respite and residential respite clients were that the client was ‘only there for a short time, not worth complaining’

(70%-72%), the client had 'no capacity to complain' (19%-25%), or they 'didn't want to be a nuisance or make a fuss' (9%-22%). In addition, a sizeable proportion of clients indicated that they did not know how to lodge a complaint at all (21%, 46%, 30% for HCP, CHSP respite and residential respite, respectively).

Figure D: Reporting and resolution of main concerns by care type



The overall proportion of main concerns that were reported unofficially was around two-thirds for each care type (mostly with family and friends). Official reporting was noticeably higher for HCP clients than the two respite groups, and most of these official complaints were to aged care staff or the aged care provider. Less than 0.1% of HCP client concerns were reported to the Aged Care Quality and Safety Commission and less than 1% in total went to it and other organisations such as My Aged Care or the National Aged Care Advocacy Program. No concerns were reported to these bodies by CHSP or residential respite clients. Whether concerns were officially reported in each care type appeared to be proportional to the clients' knowledge of and confidence in lodging complaints. When an official complaint was made, about half were not resolved to the satisfaction of HCP clients, and almost two thirds were not resolved satisfactorily for CHSP respite and residential respite clients. These rates suggest clients' low expectations about having their complaints resolved are reasonably accurate.

Impact of COVID-19

The survey was undertaken during the COVID-19 pandemic and associated restrictions and around 60% of all respondents were impacted by the situation. HCP clients thought 7.1% of their main concerns were due to COVID-19, compared to 11.7% for CHSP respite clients and only 3.5% for residential respite clients. Residential respite clients in this survey may not have accessed this service during periods of restriction. HCP and CHSP respite are ongoing services that clients were more likely to have accessed during the pandemic.

Staffing was a consistent area of concern affected by COVID-19 across all service types. Some respondents said that providers were understaffed or unable to provide continuous staffing due to staff members having family responsibilities, self-isolation requirements or being uncomfortable with the working environment. HCP and CHSP respite clients had concerns about the fees and service administration when providers cut back on provision of services or clients chose to reduce services to minimise contact with others, feeling that the fees did not reflect reduced services. Loneliness and a lack of activities to choose from were also consistent main concerns resulting from COVID-19.

The longer-term impacts are unknown but are likely to be far-reaching, particularly as the pandemic continues and restrictions have been re-introduced in some places. Access to services may be further limited or not available at all. For example, outbreaks in aged care facilities will impact availability of residential respite services. Government and industry need a comprehensive plan to understand and address any downstream issues for HCP, CHSP respite and residential respite clients.

Discussion and implications

This study has investigated a broad range of issues for HCP and respite clients in considerable detail. Ultimately, everyone who needs aged care has the right to quality of care. Although this study found that some 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.

Many of HCP and CHSP respite client concerns related to finance, administration and fees. There is a clear need to address systemic issues related to funding and administration of both HCPs and CHSP respite as well as the need for more transparency about fees and services at the client-provider interface. The positioning of people accessing aged care services as ‘consumers’ able to make informed choices about their care is also problematic: transparent and accessible information is clearly lacking; clients themselves do not perceive that they have choice and control; some older people may have less capacity to choose or switch between aged care services; and other factors make them more vulnerable than the general population². This positioning also diminishes older people’s rights as citizens and decreases government responsibility.

Lack of choice was a key area of concern for HCP, CHSP respite and residential respite clients, as it was for permanent residents but to a lesser extent. For HCP clients, the most common concerns about choice included lack of clarity about entitlements, not being able to choose who provides the services, and not being able to negotiate costs. These are all fundamental aspects of choice that the aged care system should be expected to achieve, especially for HCP clients since the program is predicated on clients being able to decide how to allocate their own budget.

CHSP respite and residential respite clients felt that they were less supported to make decisions about their care and services than HCP or permanent residential aged care clients. These clients may not receive case management or other supports in the same way that HCP and permanent residential aged care clients do. The introduction of independent case management services for all older people accessing aged care could support more choice and better decision making.

Workforce issues, such as ensuring continuity of staff, providing adequate training, poor communication between staff, and understaffing also need to be addressed as shown by the survey results. The casualisation of the aged care workforce can create problems such as staff being less able to learn the needs of each person in their care and build relationships with them; less incentive for providers to invest in skills development; and greater risk that clients might be exposed to illnesses from staff who would not be paid if they take a sick day. The problems from casualisation of the aged care workforce are then exacerbated by workforce shortages as demonstrated on a large scale during the 2nd wave of the COVID-19 pandemic when outbreaks occurred in many aged care facilities in Victoria. Both governmental and organisational level action is needed to address workforce issues to enable better continuity of care, an aspect that is important to many older people. The survey found a wide range of other concerns: how care recipients were treated; lack of support to maintain social relationships and connections with the community and many people feeling lonely or bored; the quality and accessibility of personal, medical and health care; the privacy, cleanliness and security of the respite environment outside a person’s own home; and different aspects of services for each group. Changes to how

² Henderson & Willis, 2020

aged care is regulated and funded may improve performance in some of these areas of concern by setting clearer performance standards and resourcing obligations. Targeted interventions are needed to address social isolation for HCP and respite clients beyond what is already being delivered.

In the current environment, government must manage and increase its active regulation of the sector to ensure that aged care is effective, accessible, equitable and sustainable. The government should ensure that: providers are more transparent in their finances and operations; aged care consumers are given clear and accessible information; consumers are given better support to navigate the system, make choices and obtain value; ensure there is funding to commission or support specialist or innovative providers; and the system promotes service innovation and best practice that will maximise outcomes for older people.

Clearly, the system for complaints in aged care is also not working. Many do not know how to lodge a complaint, do not feel confident making a complaint and do not have confidence their complaint will be acted upon. Most official complaints are being left unresolved and are not being reported to official complaints bodies such as the Aged Care Quality and Safety Commission. As aged care clients living in the community are, in many senses, distanced from providers and some often feel unable to report their concerns, increased measures are needed to engage them and empower them to speak up about any concerns they may be experiencing or have experienced. There is a need to develop a far more comprehensive system for capturing and resolving client concerns, and to increase regulation of the aged care sector to ensure that all aged care services are of optimal quality and are improving outcomes for older people.

The surveys we have conducted with home, respite and residential care clients provide a benchmark by which 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 sustainable. 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 that public awareness is maintained, that reforms are followed through, and that 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 care, home or respite care services.

In this, the second of the two studies, the objectives were to explore for home and respite care services:

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

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

1.2 Background

1.2.1 Home care packages

The Home Care Packages (HCP) Program provides support to older people with complex needs to help them stay at home. As of 31 December 2019, 145,320 people had access to a HCP³. There are four levels of packages, known as level 1, 2, 3 or 4 packages. Higher level packages include greater amounts of government funding, designed for clients with higher care needs. Government funding ranges from \$8785.55 for a Level 1 package to \$50,990.50 for a Level 4 package per annum.

HCP clients may be required to contribute to the cost of their care if they are able to (determined by means testing), which is paid by the client in the form of a daily fee and/or an income tested fee. Clients choose a service provider to administer and manage their HCP funds. Types of services and supports that people can access using their HCP include care management, personal care, nursing, allied health, meal preparation, domestic assistance, transport, social support, home maintenance, home modifications, and goods and equipment.

Since 2013, HCPs have been transitioning to a 'Consumer Directed Care' (CDC) model. CDC models aim to support independence and choice of care by providing information and control to consumers over what, how and when care is provided and the associated costs. This means that clients should be able to choose the services that they want to access and who provides them, have the opportunity to develop their own care plan, and be provided with transparent information about how their funds are spent. Ultimately, it is a competition-based model where, theoretically, clients can move between providers as they choose, and providers need to be competitive to gain and retain clients.

1.2.2 Commonwealth Home Support Programme respite care

The Commonwealth Home Support Programme (CHSP) provides entry-level support services for older people to live independently at home. In 2018-19, 826,335 older Australians were accessing CHSP services⁴. As an 'entry-level' program, the CHSP is designed for senior Australians who need only relatively low intensity (small

³ Australian Government Department of Health, 2020

⁴ Australian Productivity Commission, 2020

amounts) of a single service or a few services to enable them to maintain their independence. However, the types of services that people can access through CHSP are similar to those under a HCP, and clients are expected to contribute to the cost of their care if they are able.

HCPs and CHSP differ in that CHSP service providers are awarded blocks of funding to run a variety of services across a client population, whereas HCP clients are allocated a specific amount of funds to use towards their own care needs. The provider that the client chooses to deliver their approved CHSP services ultimately decides how many hours of services to deliver to the client. Respite care is one category of service delivered under CHSP, and provides planned and emergency short-term and time-limited breaks for caregivers of older adults. There are three types of respite services available through CHSP:

- Flexible respite – where a paid carer comes to the home to relieve the usual carer for a short period of time (usually an hour or two)
- Centre-based respite – where the client goes to a facility (usually a day centre, club or residential setting) for a day where they can talk and interact with other people
- Cottage respite – where the client stays overnight or over a weekend somewhere in the community or in the home of a host family

1.2.3 Residential respite services

Residential respite refers to a time-limited (a few days to a few weeks) stay in a residential aged care facility that aims to provide relief for the person's carer. People who access residential respite care usually need ongoing, continuous support for most tasks. People can access up to 63 days of residential respite per financial year. Residential respite services are subsidised through the Australian government⁵. A proportion of all funding allocated by the Commonwealth to approved individual age care providers must be used towards respite care (a certain amount of respite days must be used by these approved providers). The subsidy that the provider receives is dependent on the level of care needed to support each client (low, medium or high). Residential respite clients may also be eligible for additional funding supplements, including for enteral feeding, oxygen, hardship and viability.

1.2.4 Quality in home and respite 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 choice⁶. There are many challenges to 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 quality³.

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 residential aged 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, 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 capturing the views and experiences of people accessing aged care services. This

⁵ Australian Government Department of Health, 2020

⁶ COTA Australia, 2018

is reflected in the new Aged Care Quality Standards used by the Aged Care Quality and Safety Commission (ACQSC).

The evaluation of quality in aged care has focused primarily on residential care. However, there have been efforts to better capture the experiences of community aged care consumers in recent years⁷. The ACQSC is currently expanding the Consumer Experience Report (CER) into the home and community aged care sector. Pilot testing began in November 2018. Although published reports are not currently available to the public, results from the pilot testing have been published by Latrobe University⁸. A total of 273 interviews were conducted with HCP or CHSP clients (or their proxies). Results indicated that overall, HCP and CHSP clients were mostly satisfied with the quality of their care. For example, over 90.0% of clients indicated that they felt that staff treated them with respect. However, a notable proportion of clients were unsatisfied in many of the domains measured. For example, 31.0% of clients indicated that they ‘never’ or ‘some of the time’ got value for money for their services. A large proportion (29.0%) indicated that they ‘never’ or ‘rarely’ understood the information they were given about their services. Many clients (43.0%) indicated that their services were ‘never’ or ‘rarely’ updated. When assessing quality of care through measures such as these, it is important to consider that while a large proportion of respondents may indicate that they are satisfied, the proportion of clients indicating that they are unsatisfied (even if small) is worthy of attention.

Reforms over the last five years, including *Increasing Choice in Home Care (IHC)*, have aimed to increase the quality of home care services delivered to older Australians, especially through providing consumers with more choice and motivating providers through the implementation of a more competition-based system⁹. Market research has revealed that consumers like that HCPs are now more portable, services are more flexible, and that funding is more transparent than under previous systems¹⁰. However, it has also revealed that consumers are dissatisfied with areas including high administration and other fees¹¹. There remains a clear need to assess quality of home and respite care services and how they affect quality of life.

Judgements about quality of care and associated consequences are largely left to be determined by the people accessing HCP and respite services. The CDC system is premised on the idea that providers need to compete to gain and retain clients and will therefore be motivated to provide high-quality care¹². It is assumed that when care is of high quality, consumers will be more likely to ‘choose’ those services. Conversely, when care is substandard, it is assumed that consumers will shift to services that are better quality. The system is therefore ideologically conceived as able to meet people’s care needs with less need for government regulation or intervention. That ideology can be seen as flawed since in reality, consumers are limited in their ability to make informed choices¹³.

Older people may also face barriers to making well-informed choices, exercising those choices or identifying or expressing when they have concerns about the quality of their care. For example, some older people have cognitive difficulties, difficulties communicating, or may have deteriorating health that impedes their capacity to act as a consumer in a free market. The aged care system (particularly the system for home and respite care) is also extremely complex to navigate. Additionally, ‘consumers’ may not have access to the information necessary to determine the potential quality of aged care services before making a choice, or even have much real choice if they are in a ‘thin’ market without many providers. Once they have chosen a service or provider,

⁷ Wells & Fetherstonhaugh, 2019

⁸ Latrobe University, 2019

⁹ LASA, 2018

¹⁰ AMR, 2018

¹¹ Russell et al., 2020

¹² Brotherhood of St Laurence, 2020

¹³ Henderson & Willis (2020)

they may not have capacity or incentive to move to another. HCP providers sometimes charge a large exit fee when clients move to another provider, meaning that clients are disincentivised to move, even when they are unsatisfied with their service. Furthermore, clients are likely to experience similar issues no matter which provider they choose. This is due to systemic issues such as large administrative fees charged by most providers, inadequacies in the aged care workforce and the potential for care quality to be deprioritised^{14,15,16,17,18}, all of which are products of the system.

1.2.5 Substandard care

Aged care providers 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. Substandard care can also involve interpersonal elements, such as how residents are treated and whether their needs, wants and preferences are given due respect.

1.2.6 Concerns and complaints

Substandard care is most often expressed in the form of ‘concerns’ and acted upon in the form of ‘complaints’. In Australia, aged care clients can express dissatisfaction with care by complaining to their service provider, and to bodies such as the ACQSC, My Aged Care, the Older Persons Advocacy Network, and the Commonwealth Ombudsman. For example, in 2018-2019, Australia’s ACQSC received 1,552 complaints relating to HCPs (20.0% of all complaints received) and 451 relating to CHSP services (6.0% of all complaints received)¹⁹. The most common complaint issues for both HCPs and CHSP were fees and charges, lack of consultation and communication, and inconsistent client care and coordination. However, despite this data being available, in-depth information about the complaints, the rate of unreported incidents of substandard care and the reasons why home and respite clients and their families do not report these incidents has not been investigated in a systematic way.

For this study, we were interested in understanding ‘concerns’, defined as home and respite care clients and their representatives’ perceived negative experiences with the services they access, 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).

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. In recognition of this, the opening sentence of the ACQSC’s ‘Making a Complaint’ webpage states that “making a complaint is not ‘being difficult’”²⁰.

¹⁴ Henderson & Willis, 2020

¹⁵ Davidson, 2018

¹⁶ Davidson, 2015

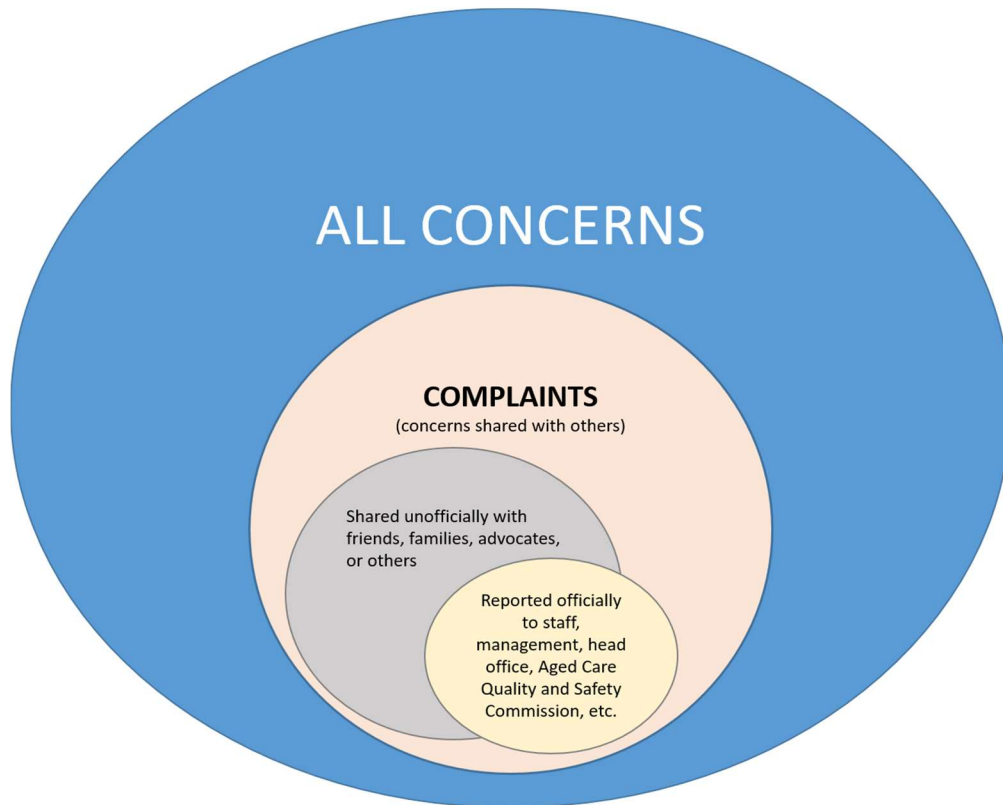
¹⁷ Brotherhood of St Lawrence, 2016

¹⁸ Brotherhood of St Lawrence, 2020

¹⁹ Aged Care Quality and Safety Commission, 2019

²⁰ Aged Care Quality and Safety Commission, 2020

Figure 1: Concerns and complaints



2 Method

Telephone interviews were conducted with a representative random sample of individuals (or their proxies) who were receiving either a HCP, CHSP respite services, or residential care respite services. The interviews collected demographic and service use information in addition to questionnaires measuring quality of care, life satisfaction, and concerns and complaints.

2.1 Ethics

This project received ethics approval from the Bellberry Human Research Ethics Committee (HREC), application number 2020-02-131.

2.2 Sample selection

Participants were a random sample of nationally representative clients who were:

- Currently receiving a HCP (Level 1-4), OR
- Were currently or previously (in the last 6 months) receiving:
 - CHSP respite services (centre-based respite, cottage respite or flexible respite), OR
 - Residential care respite services (planned or emergency)

The Royal Commission provided lists of random samples of clients from all groups under its legal authority. These lists did not contain personal identifiers and were held securely by NARI and Ipsos to be used only for this survey. Only essential data needed to conduct the survey was obtained: contact phone numbers, the state in which clients resided to determine best calling times, and the client's preferred language to determine whether an interpreter was needed. The list included clients who were in receipt of HCP or CHSP respite services as of July 2019, and residential respite clients who had received respite in the period November 2019-January 2020.

2.2.1 Participants

The target number of interviews was n=1200, with sub-targets of n=200 for each category (each of HCP Levels 1-4, CHSP respite, and residential respite).

A sampling frame of 9600 people across the six categories was selected by simple random sampling using SAS software (1600 from each of the six categories, to oversample by a factor of 8). The sample was proportionally stratified by State/Territory, remoteness (major city, inner regional, and outer regional²¹), and provider type (profit, non-profit, government).

Clients receiving both a HCP and either CHSP or residential care respite services were excluded to minimise respondent confusion about the services being queried and to ensure that responses were specifically about the HCP services received. Clients were able to nominate a representative to speak on their behalf provided they were over the legal age, had the capacity to provide consent themselves, and were not a paid care worker.

Table 1, Table 2 and Table 3 show the sampling frame for each of the sub-categories, drawn from lists of clients provided by the Royal Commission.

²¹ Remoteness categories based on ASGS categories remoteness structure, but collapses Outer Regional Australia, Remote Australia and Very Remote Australia into one category

Table 1: Sampling frame of HCP clients by level, remoteness and provider type

	Level 1	Level 2	Level 3	Level 4	Total
Major Cities of Australia	993	1013	1041	1055	4102
Non-Profit	612	728	723	755	2818
For Profit	340	211	252	240	1043
Government	41	74	66	60	241
Inner Regional Australia	410	390	366	334	1500
Non- Profit	252	234	224	218	928
For Profit	72	56	64	48	240
Government	86	100	78	68	332
Outer Regional/Remote/Very Remote	139	231	173	259	802
Non-Profit	66	87	74	94	321
For Profit	10	66	45	120	241
Government	63	78	54	45	240
Total	1542	1634	1580	1648	6404

Table 2: Sampling frame of CHSP respite clients by remoteness and provider type

Location	Sample frame total
Major Cities of Australia	1016
Non-Profit	672
For Profit	152
Government	192
Inner Regional Australia	344
Non-Profit	240
For Profit	48
Government	56
Outer Regional/Remote/Very Remote	240
Non-Profit	136
For Profit	40
Government	64
Total	1600

Table 3: Sampling frame of residential respite clients by remoteness

Location	Sample frame total
Major Cities of Australia	960
Inner Regional Australia	400
Outer Regional/Remote/Very Remote	240
Total	1600

2.2.2 Recruitment procedures

In the initial phase, an introduction letter from the Royal Commission was sent to half of all randomly selected clients informing them of the study. Interviewers then randomly called clients until the number of required participants were reached (target n=200 in each category). The second half of the randomly sampled clients were kept as a reserve, to be sent letters if the targets were not reached.

Interviewers attempted contact with a client on a maximum of five occasions. If a client was reached, they were invited to complete one 45-minute telephone interview at a time convenient to them. Interviewers emphasised that participation was voluntary and assessed potential respondents' capacity to participate. If an interpreter was required, either a bi-lingual member of the interviewing team conducted the interview or an independent interpreter was used.

All participants provided verbal informed consent. Experienced interviewers were trained by a Clinical Neuropsychologist to determine whether respondents had the capacity (including the cognitive capacity) to provide informed consent and to participate in the interview. Where clients were deemed unable to provide consent and complete the interviews themselves, they were invited to nominate a representative to complete the interview on their behalf.

Interviewers monitored participants throughout 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 participant displayed any lapse or fluctuation in their capacity to participate, or they wished to stop for any reason.

2.3 Participant safety and confidentiality

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

- Names of participants were not collected. Regional locations of the participants were kept confidential. No potentially identifying information was provided to the Royal Commission.
- In order to minimise any potential influence from aged care providers, participants were approached directly, and aged care providers and facility staff were not informed who was invited to participate.
- Specific complaints or incidents of substandard care disclosed by the respondents were not reported to any external organisations. Participants 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 any complaints discussed.
- Interviewers had current Working with Vulnerable People accreditation and a current Police Check.

2.4 Interview process

Telephone interviews commenced on 16 April 2020 and were completed on 4 June 2020, a period during which Australia was experiencing the first wave of the COVID-19 pandemic.

Participants completed a Computer Assisted Telephone Interviewing (CATI) survey comprising the questionnaires described in detail below. All interview data were collected by Ipsos interviewers and entered electronically into the CATI system. Basic demographic information was collected including age, sex, and duration of service provision. Residential respite clients were asked to share the name of the RACF at which they stayed if it was known. HCP respondents were also asked whether they had accessed the following types of services in the last 6 months:

- Personal care
- Nursing care
- Allied Health services
- Respite care
- Meal preparation
- Social support
- Transport
- Domestic assistance

- Goods, equipment and assistive technology
- Home modifications
- Home maintenance

The average duration of the interview was 45 minutes, with some variation depending on the number of concerns or complaints described by the respondent.

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. **General Life Satisfaction (GLS)**²³: a single rating out of 10 designed to measure subjective wellbeing and life satisfaction consistent with the version used in the Survey of Health, Ageing and Retirement in Europe (SHARE).
3. **Control, Autonomy, Self-realisation and Pleasure 12-item (CASP-12) questionnaire**²⁴: an internationally-recognised and academically validated measure of quality of life in older ages, consistent with the version used in SHARE.
4. **The Adult Social Care Outcomes Toolkit (ASCOT) questionnaire (SCT-4)**²⁵: a validated measure of quality of life that is affected by social or community care across eight domains: control over daily life, personal cleanliness and comfort, food and drink, personal safety, social participation and involvement, occupation, accommodation cleanliness and comfort, and dignity.
5. **Client Feedback Questionnaire (CFQ)**: a new questionnaire examining concerns and complaints, including who complaints were made to and whether they were resolved.

2.5.1 Quality of Care (QoC)

Respondents 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 were:

- 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 the Flinders University. The questions were previously used in a Discrete Choice Experiment for the Royal Commission²⁶.

²² Ratcliffe et al., 2020

²³ SHARE, 2020

²⁴ Wiggins et al., 2008; Borrat-Besson et al., 2015

²⁵ Malley et al., 2012

²⁶ Ratcliffe et al., 2020

2.5.2 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) survey²⁷ and the Household, Income and Labour Dynamics in Australia (HILDA) survey²⁸. This question was asked twice: once to measure subjective wellbeing at the time of the interview, and then again to measure subjective wellbeing for the period before the COVID-19 pandemic.

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?

Now thinking about life in general before the COVID-19 pandemic: 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?

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

General quality of life (QoL) was measured using the version of the CASP-12 that was adapted by the SHARE survey (Table 4)²⁹. 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.

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	

2.5.4 Adult Social Care Outcomes Toolkit (ASCOT)

The ASCOT questionnaire (SCT-4) is a tool to measure an individual's quality of life that may be affected by social care (aged care). The reliability and validity of the ASCOT (SCT-4) has been thoroughly tested and the psychometric properties have shown to be reliable in the older Australian population³⁰. The questionnaire measures eight aspects of quality of life: control over daily life, personal cleanliness and comfort, food and drink, personal safety, social participation and involvement, occupation, accommodation cleanliness and comfort, and dignity. For each domain, respondents select one of the four options which relate to: 'ideal state', 'no needs', 'some needs', and 'high needs'. The total score is converted into an index score using preference-based weights, with 1 being the ideal state and 0 being the worst state, called social care-related quality of life (SCRQoL). Table 5 provides the individual items and responses.

²⁷ SHARE, 2020

²⁸ Ambrey & Fleming, 2013

²⁹ Borrat-Besson et al., 2015

³⁰ Cardona, Fine et al., 2017

Table 5: ASCOT SCT-4

Domains and questions	Responses
Control over daily life Which of the following statements best describes how much control you have over your daily life? By 'control over daily life', we mean having the choice to do things or have things done for you as you like and when you want.	• I have as much control over my daily life as I want • I have adequate control over my daily life • I have some control over my daily life, but not enough • I have no control over my daily life
Personal cleanliness and comfort Thinking about keeping clean and presentable in appearance, which of the following statements best describes your situation?	• I feel clean and am able to present myself the way I like • I feel adequately clean and presentable • I feel less than adequately clean or presentable • I don't feel at all clean or presentable
Food and drink Thinking about the food and drink you get, which of the following statements best describes your situation?	• I get all the food and drink I like when I want • I get adequate food and drink at OK times • I don't always get adequate or timely food and drink • I don't always get adequate or timely food and drink, and I think there is a risk to my health
Personal safety Which of the following statements best describes how safe you feel? By 'feeling safe' we mean how safe you feel both inside and outside the home. This includes fear of abuse, falling or other physical harm.	• I feel as safe as I want • Generally I feel adequately safe, but not as safe as I would like • I feel less than adequately safe • I don't feel at all safe
Social participation and involvement Thinking about how much contact you have with people you like, which of the following statements best describes your social situation?	• I have as much social contact as I want with people I like • I have adequate social contact with people • I have some social contact with people, but not enough • I have little social contact with people and feel socially isolated
Occupation Which of the following statements best describes how you spend your time? When you are thinking about how you spend your time, please include anything you value or enjoy, including leisure activities, formal employment, voluntary or unpaid work, and caring for others.	• I'm able to spend my time as I want, doing things I value or enjoy • I'm able to do enough of the things I value or enjoy with my time • I do some of the things I value or enjoy with my time, but not enough • I don't do anything I value or enjoy with my time
Accommodation cleanliness and comfort Which of the following statements best describes how clean and comfortable your home is?	• My home is as clean and comfortable as I want • My home is adequately clean and comfortable • My home is not quite clean or comfortable enough • My home is not at all clean or comfortable
Dignity (having help) Which of these statements best describes how having help to do things makes you think and feel about yourself?	• Having help makes me think and feel better about myself • Having help does not affect the way I think or feel about myself

Domains and questions	Responses
	• Having help sometimes undermines the way I think and feel about myself • Having help completely undermines the way I think and feel about myself
Dignity (the way help is provided) Which of these statements best describes how the way you are helped and treated makes you think and feel about yourself?	• The way I'm helped and treated makes me think and feel better about myself • The way I'm helped and treated does not affect the way I think or feel about myself • The way I'm helped and treated sometimes undermines the way I think and feel about myself • The way I'm helped and treated completely undermines the way I think and feel about myself

2.5.5 Client Feedback Questionnaire (CFQ)

The CFQ was adapted from a questionnaire designed in conjunction with the Royal Commission for the separate survey of residents living in residential aged care facilities and is set out in the appendix of that report³¹. The questionnaire is comprised of two components: (A) concerns of the client (itemised list of concerns and top three main concerns), and (B) actions taken regarding concerns – such as complaints.

Three different versions of the CFQ were developed and tailored to the three different care types: HCP, CHSP respite, and residential respite. For Section A, respondents were asked to itemise any concerns they have had in the last 6 months in domains as listed in Table 6. Each domain comprised different areas of concern (see the Appendix Table 35, Table 36 Table 37 for full details). Respondents were also able to provide detail of any other concerns that were not already listed within each domain. The questions were scripted to be delivered in the CATI format, and the questionnaires were customised to make them suitable for administration to proxies when required.

If respondents from any of the service groups identified any concerns in Section A, they were asked to select their top three main concerns at the start of Section B. These represent the concerns that were most important to the client. For each of these three concerns, respondents were asked to identify actions taken (that is, any official or unofficial complaints) and resolution, if any. This included identifying whether they discussed the concern with another person, for example, a family member or friend, doctor, aged care staff or case management, respite service provider, or official complaint body. In addition, respondents were asked to provide detail about the resolution, if any. If a complaint was made directly to staff, management, the aged care organisation, the ACQSC or other formal channels, respondents were asked if the complaint was resolved to their satisfaction. If those complaints were not resolved to their satisfaction, respondents were asked why not. If the client discussed 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. If so, they were asked if the complaint was satisfactorily resolved. There was also an opportunity for respondents to provide free responses, and these were recorded.

For each of the three main concerns, respondents were also asked to indicate whether they believed the concerns identified were due to funding issues (i.e. amount of funding available to them, not management of funds) or due to the COVID-19 pandemic. The reason for this was to attempt to identify concerns that may

³¹ Batchelor et al., 2020

have been influenced by broader government policies and/or COVID-19 responses. For example, a client may indicate that they have concerns about lack of choice in attending activities, but this may be because COVID-19 restrictions have limited access to those activities. Concerns may stem from a multitude of issues and it is likely that respondents may not always have clear insight into the often complex nature of these issues; therefore, responses to these questions should be interpreted with caution.

Table 6: Client Feedback Questionnaire domains by care type

Type of service	Domains of the Client Feedback Questionnaire
HCP	• Management, finances and administration • Services • Personal or medical care • Equipment, home maintenance or home modification services • Home care staff • Dignity and respect • Choice
CHSP respite	• Finances and administration • Services • Staff • Dignity and respect • Choice • Personal or medical care • Respite environment
Residential respite	• Dignity and respect • Personal care • Medical and health care • Choice • Staff • Client's room • Facility • Services

2.5.6 COVID-19 impact questions

Given the survey was conducted during the first wave of the COVID-19 pandemic, three open-ended questions were also included at the end of the survey to assess the impact of COVID-19 on clients' circumstances and needs, and how this may have affected the services being delivered by providers.

- How have your circumstances or needs changed due to COVID-19?
- Has COVID-19 changed your use or opinion of your home care/respite services?
- How has your service provider responded to COVID-19? For example, in providing information, altering services or providing additional support.

2.6 Proxy respondents

In cases where the proxy (i.e. client's nominated representative) was responding instead of the client receiving services, they were asked to respond *on behalf* of the client; that is, providing responses that, in their best estimation, the client would have provided.

A total of 1,223 interviews were completed (865 for HCP, 155 for CHSP respite and 203 for residential respite). Overall clients (not proxies), comprised 50.2% of the total number of respondents to this survey. The

proportion of interviews that were completed with a representative on clients' behalf varied between care types.

There is some evidence to suggest that proxies may overestimate physical and cognitive impairment and underestimate quality of life of the person they are responding for³². In particular, proxies commonly score others as more depressed and less optimistic than the person scores themselves³³. However, family members (spouses, in particular) may be more reliable than friends or healthcare workers on most measures, showing more similar scores to clients on objective rather than subjective measures³⁴. One study suggests that proxies and people with dementia may conceptualise quality of life differently and it may be beneficial to assess quality of life using more than one measure³⁵.

Approximately two weeks into the interview period, it was noted that a higher than expected proportion of interviews were being completed by proxies. Interviewers noted that, at times, they felt proxies were 'gatekeeping' or were otherwise reluctant to give the phone to the client, and could not be sure in how many instances the client may have had the capacity to complete the interview had they been given the opportunity. Thus, interviewers began to emphasise to client representatives the importance of giving clients the opportunity to have a voice and to share their own experiences if they are able. The remaining 35.0% of proxies were then asked to indicate why they were responding on behalf of the client receiving services (n=378). They were able to indicate multiple reasons. The most common reasons given by proxies of clients across all service categories for completing the survey were that the client had dementia or Alzheimer's disease, deafness, or other cognitive difficulties. Responses indicating dementia of any cause or Alzheimer's disease were combined into a single category due to these terms often being used interchangeably by the general public. All reasons and unweighted percentages across the service categories for requiring proxy interviews are listed in Table 7.

Proxies caring for clients in either of the respite groups were also asked how helpful the respite services are in providing relief for them as a carer of the client.

Table 7: Reasons for interviews being completed by proxies (unweighted % of proxy interviews)

Reported reason for needing proxy	HCP (%)	CHSP respite (%)	Residential respite (%)
Dementia (including Alzheimer's disease)	45.5	56.5	45.5
Deafness	12.1	17.4	27.3
General cognitive difficulties	9.1	10.9	18.2
Stroke	6.1	5.4	0.0
Too old/frail	6.1	7.6	4.5
Language barrier	0.6	3.2	0.0
Parkinson's	0.2	4.5	0.5
Deceased	0.2	1.9	0.0
Unable to speak	0.1	0.6	0.5
Poor mental health	0.1	1.3	0.5
Blind	0.1	0.6	0.0
Permanently living in residential care	0.0	3.3	0.0
Other	6.1	2.2	0.0
Total % of all interviews completed by proxy	31.7	76.8	60.1

³² Usman, 2019

³³ Skolarus, Sanchez et al., 2010

³⁴ Elena, Victoria et al., 2001

³⁵ Griffiths, 2020

2.7 Statistical analyses

The data set was weighted to be representative of the HCP, CHSP respite and residential respite populations in Australia. Weights were applied separately to each of these groups. HCP weights were derived according to the distribution of provider organisation type and client remoteness within each HCP level. HCP weights also took into account the distribution of HCP levels in the population so that analyses within the entire HCP study sample were proportionally representative between levels. Weights for the CHSP respite group were derived according to provider organisation type and remoteness. Weighting for the residential respite group only took remoteness into consideration; provider organisation type was later determined from clients' responses during the survey, as this information was not readily available for all potential participants in the initial sample from which the random sample was drawn.

Analyses were conducted using SPSS Version 26.0³⁶. Descriptive analyses were used to characterise the study sample. Results are presented from analyses conducted on the weighted dataset, unless otherwise indicated.

The denominator for all weighted percentages from part A of the CFQ was all clients in each respective service group (HCP, CHSP respite, residential respite) – 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 in each service group – this encompasses all results regarding main concerns, reporting and resolution for each of those main concerns.

Chi-square analyses were conducted where the measures were categorical to test whether the observed distributions between two categorical measures was 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. Wilcoxon matched-pair signed-rank tests compared general life satisfaction scores pre-COVID-19 and currently. Pearson correlations assessed whether there were any statistically significant associations between total number of concerns and quality of life and life satisfaction measures. Due to the negative binomial distribution of total number of concerns, these were analysed using negative binomial regressions. Analyses between aged care provider types for the residential respite sample were conducted excluding participants for whom the provider type was not known. Significance was set at $p < 0.05$. Boxplots display median and interquartile range (IQR) and are shown when the variable of interest was not normally distributed.

³⁶ IBM Corp, Armonk, NY

3 Home Care results

3.1 Recruitment

A total of 865 interviews were completed with the HCP group (Table 8). Two hundred and seventy-four (31.7% of the total) were completed by a nominated representative (proxy) and 57 (6.6%) required an interpreter. The percentage of interviews completed by proxies significantly increased with HCP level (14.3% of Level 1; 19.6% of Level 2; 36.9% of Level 3; and 53.3% of Level 4).

Table 8: Number of completed HCP interviews by level, region and provider type

	Level 1	Level 2	Level 3	Level 4	Total n
Major Cities of Australia					
Non-Profit	67	135	96	110	408
For-Profit	25	36	28	33	122
Government	<5	12	12	10	39
Inner Regional Australia					
Non-Profit	25	51	31	30	137
For-Profit	<5	9	10	6	29
Government	<5	13	11	9	41
Outer regional/Remote/Very Remote					
Non-Profit	7	7	6	13	33
For Profit	<5	6	<5	11	21
Government	<5	17	6	7	35
Total n	147 (17.0%)*	286 (33.0%)*	203 (23.5%)*	229 (26.5%)*	865 (100%)

*unweighted percentages reported

3.1.1 Change in HCP levels

Given the 9-month gap between the most recent HCP client data available and commencing the survey, only half (50.4%) of the respondents reported receiving the same level of HCP at the time of the interview. Most of the changes represented clients moving to higher level HCPs (36.2% of the total HCP sample). In this time, some clients who were listed as receiving CHSP or residential respite services also transitioned to receiving HCPs instead (8.9% and 0.3% of the HCP sample, respectively).

A small proportion of HCP clients indicated receiving a lower level HCP at the time of interview compared to the sample data provided by the Royal Commission (3.8%). This was surprising as the HCP program is structured for clients to move to higher HCP levels rather than down to lower ones, and may reflect some confusion on the clients' part regarding which HCP level they are receiving.

The target of 200 interviews was not met for Level 1 because the majority of contacted respondents from the sample list reported having moved to higher HCP levels and were therefore categorised according to their current level.

3.2 Demographics

Around two-thirds of survey respondents were female and a third male (unweighted percentage 68.0% and 32.0% respectively; Table 9). The majority of participants (78.2%) were between the ages of 75 and 94; 42.1% were between the ages of 75 and 84. Only 3.3% of respondents were over the age of 95, and 51.4% of those aged over 95 were receiving a level 4 HCP. See Appendix Table 38 for the demographics by HCP level.

Most respondents had been receiving their HCP for 1-5 years (77.7%). Of the 13.4% who had been receiving their HCP for less than a year, most were currently receiving a Level 2 HCP (45.0%). A smaller proportion of people (7.8%) had been receiving a HCP for over six years; of these, most were currently receiving a Level 4 HCP (59.0%).

Table 9: Demographic characteristics of HCP respondents, n=865

Characteristic	n (unweighted)	Unweighted %	Weighted %
Sex			
Female	588	68.0%	67.6%
Male	277	32.0%	32.4%
Age (years)			
45-54	<5	0.3%	0.3%
55-64	14	1.6%	1.3%
65-74	146	16.9%	16.3%
75-84	369	42.7%	42.1%
85-94	304	35.1%	36.1%
95+	27	3.1%	3.3%
Prefer not to say	<5	0.2%	0.5%
HCP Duration			
Less than 1 year	135	15.6%	13.4%
1-2 years	418	48.3%	49.5%
3-5 years	233	26.9%	28.2%
6+ years	69	8.0%	7.8%
Don't know	10	1.2%	1.1%

3.3 Use of services among HCP clients

HCPs are designed to provide support for a diverse range of clients, from clients with basic care needs (Level 1) through to clients with high care needs (Level 4). Services can be broadly divided into three main categories: services that keep a client well and independent (personal care, nursing, allied health, specialised support, meal preparation and diet), services that keep a client safe in their home (domestic assistance, home maintenance, home modification, goods and equipment and assistive technology), and services that keep a client connected with their community (transport, social support)³⁷.

The most common service received through HCPs was domestic assistance or cleaning (90.1%). Respite services were the least accessed service (10.4%; Table 10). About half of the HCP sample had accessed personal care, allied health, and transport services as well as goods, equipment and assistive technology and home maintenance in the previous six months. The proportion of clients using each service type increased significantly as HCP level increased ($p < 0.001$), except for transport services, home maintenance, meal preparation and domestic assistance/cleaning.

The reported use of personal care, nursing, and allied health all doubled or more between HCP Levels 1 and 4. Clients on HCP Levels 3 and 4 were around twice as likely to use meal preparation services as clients on HCP Levels 1 and 2. Use of goods, equipment and assistive technology more than tripled between HCP 1 and 4. However, about half of respondents accessed home maintenance regardless of their HCP level, and most HCP clients used domestic assistance. For the services that support a client interacting with their community, use of social support services increased with increasing HCP levels, whilst the use of transport services was similar for most HCP levels.

³⁷ <https://www.myagedcare.gov.au/help-at-home/home-care-packages>

Table 10: Percentage of HCP clients by level and type of services received in the last 6 months

Service type	Level 1	Level 2	Level 3	Level 4	All levels
Personal care	15.7%	30.2%	51.2%	74.5%	45.8%
Nursing care	5.6%	8.8%	23.4%	35.1%	18.9%
Allied health	37.1%	48.9%	56.6%	73.8%	56.5%
Respite care	3.4%	8.8%	9.8%	15.6%	10.4%
Meal preparation	16.9%	13.8%	28.8%	31.0%	21.9%
Social support	22.5%	31.7%	37.6%	40.1%	34.5%
Transport	63.0%	51.3%	49.3%	50.0%	49.2%
Domestic assistance	86.5%	90.8%	94.6%	87.1%	90.1%
Goods, equipment & assistive technology	18.0%	33.9%	54.6%	61.9%	44.6%
Home modifications	18.0%	21.7%	30.2%	33.1%	26.3%
Home maintenance	41.6%	49.5%	52.7%	47.0%	48.7%

3.4 Quality of care

In general, the results from the Quality of Care questionnaire indicate a proportion of HCP respondents are satisfied with their care experience but there is a large share only partially satisfied and a significant minority with low satisfaction.

For individual items, around 50% of HCP respondents were ‘always’ satisfied except for being treated with respect and dignity (76.3%) and being supported to make their own decisions about care and services (62%). In each domain roughly 20% to 30% of respondents were ‘mostly’ satisfied, except for knowing how to lodge complaints where the proportion was much lower (Figure 2 and Table 39 in the Appendix).

Almost 6.0% reported that they were ‘sometimes’, ‘rarely’ or ‘never’ treated with respect and dignity and 14.3% said they only sometimes (or less often) received the support to make their own decisions about the care and services they receive. Around 13% said they only sometimes (or less often) received support from appropriately skilled and trained staff, while 15.5% said they only sometimes (or less often) received the support and services they felt were important for their health and well-being. Around 30.2% felt unsupported in maintaining their social relationships and community connections. There were also large shares of HCP respondents with low satisfaction in the complaints related areas: 38.9% of the sample indicated that they only sometimes (or less often) knew how to lodge a complaint, 34.3% were only sometimes (or less often) comfortable making complaints, and 22.5% were only sometimes (or less often) confident action would be taken.

When looking at individual HCP respondents’ responses as a whole, 23.4% were ‘always’ satisfied in all areas, 32.5% were at least ‘mostly’ satisfied in all areas (not including ‘always’ in all areas) and 44.1% were ‘sometimes’ or less often satisfied in any area.

Overall, there was no clear pattern in results of the Quality of Care questionnaire across the four levels of HCP, although there were some differences in individual items. For the item ‘received services and support for daily living’, responses were significantly more positive with increasing HCP level ($p=0.007$). HCP Level 2 respondents were significantly more likely to respond ‘always’ compared to the other levels for the item ‘supported to make decisions’ ($p=0.01$) and for the item ‘comfortable lodging complaints’ ($p=0.001$). See Table 40, Table 41, Table 42 and Table 43 in the Appendix.

Figure 2: Quality of care – HCP clients: percentage by response category

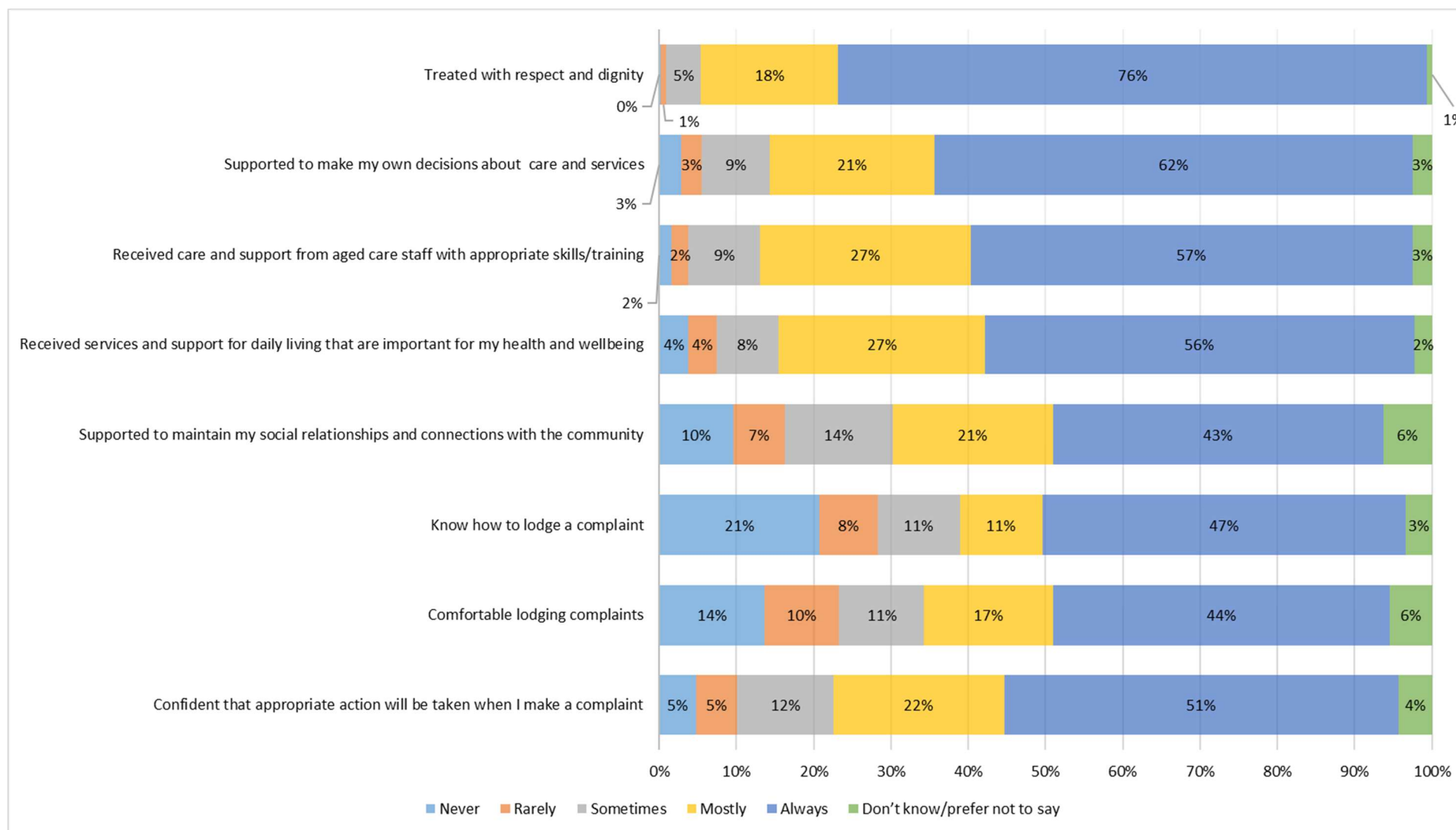
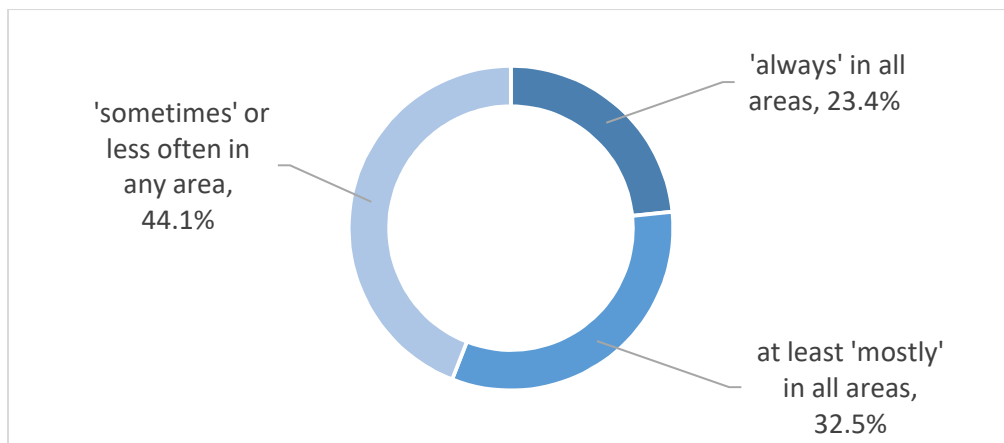


Figure 3: Quality of Care – HCP clients: percentage across areas



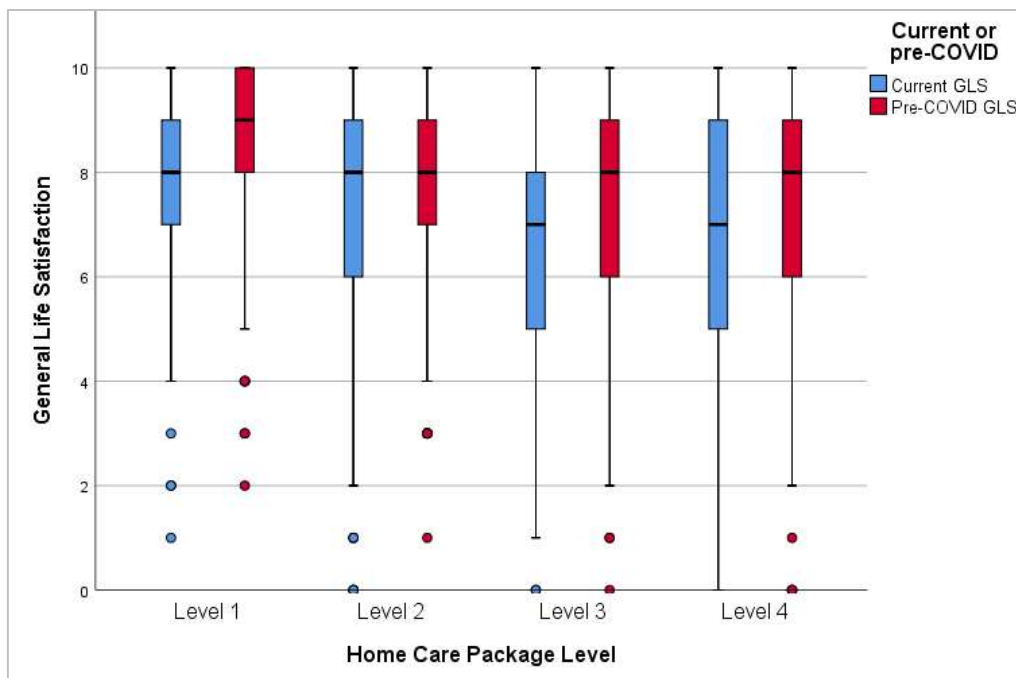
NB Excludes responses to complaints related items; excludes 'don't know' answers; 'mostly' category excludes those who answered 'always' in all areas

3.5 Life satisfaction and quality

3.5.1 General life satisfaction

GLS scores ranged from 0.0-10.0 (where 10 is the highest GLS). Mean GLS for all HCP respondents at the time of the interviews was 7.2 (SD 2.2) with a median of 8.0 (IQR 6.0-9.0). When asked to rate their satisfaction with life before the COVID-19 pandemic, the mean was 7.7 (SD 2.1) with a median of 8.0 (IQR 7.0-9.0). This decrease in GLS when comparing pre-COVID estimates to GLS at the time of the interview was significant across and within all HCP levels ($p < 0.05$) (Figure 4).

Figure 4: GLS scores pre- and during COVID-19 restrictions by HCP level



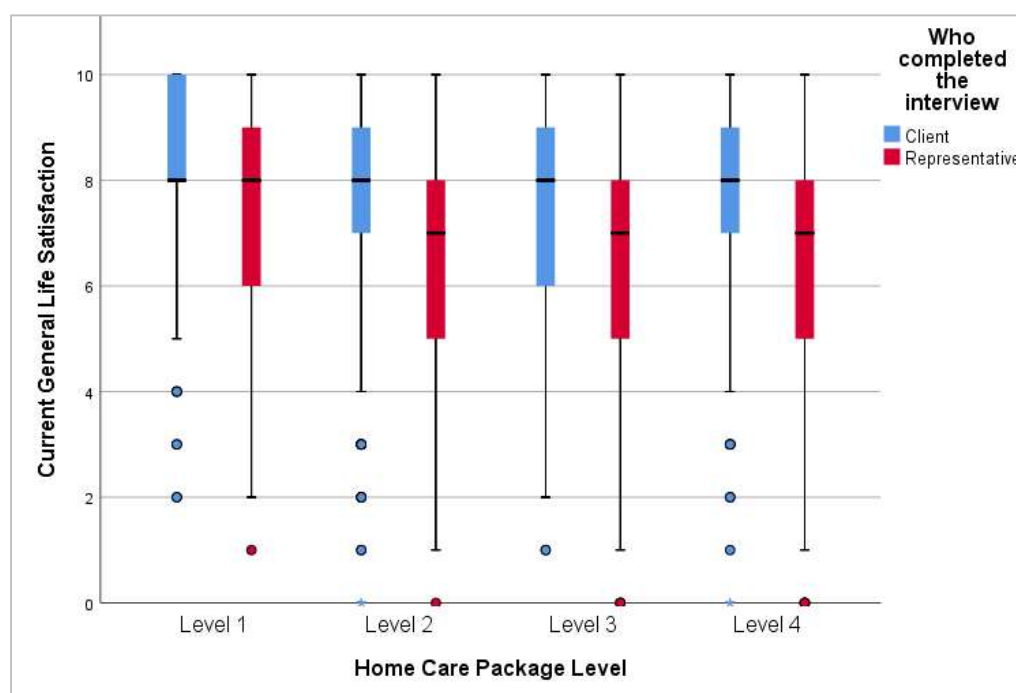
NB: Median scores and IQR shown

Overall, GLS decreased from HCP Level 1 to Level 4 ($p < 0.001$). Differences in GLS by provider type or remoteness were only observed in the Level 4 group. In this group, current general life satisfaction was higher for clients with for-profit compared to non-profit providers, with government providers falling in between. General life satisfaction in people living in inner regional areas (median 8.0, IQR 7.0-9.0) was also significantly

higher than for people in major cities (median 7.0, IQR 5.0-8.0; $p=0.009$), with outer regional areas falling in between (median 7.4, IQR 7.0-9.7). No differences were observed for clients on Levels 1-3.

Across all HCP levels, GLS was rated to be lower when interviews were completed by proxy compared to when clients completed interviews ($p<0.05$; Figure 5). This is consistent with previous research suggesting that proxy respondents tend to underestimate clients' life satisfaction and perceived quality of life³⁸. This may reflect that proxy respondents perceive clients' life satisfaction and quality of life as poorer than the client themselves would express.

Figure 5: Comparison of GLS by respondent type and HCP level



NB: median scores and IQR shown

3.5.2 General quality of life

Analyses of quality of life in general, as measured by the total CASP-12 score, were restricted to participants who responded to every question on the CASP-12 (91.7% of the sample). The results were not significantly different when all participants were included by scoring unanswered questions as 0.

Total CASP-12 scores for HCP clients ranged from 14 to 48 (where 48 indicates the highest possible self-reported quality of life), with a mean of 34.2 (SD 6.2) and a median of 34.0 (IQR 30.0-39.0). This differed significantly between HCP levels ($p<0.001$; Figure 6). CASP-12 scores for Levels 1 and 2 HCP clients (means 36.2, 35.1) were higher than for Levels 3 and 4 HCP clients (means 32.8, 33.1).

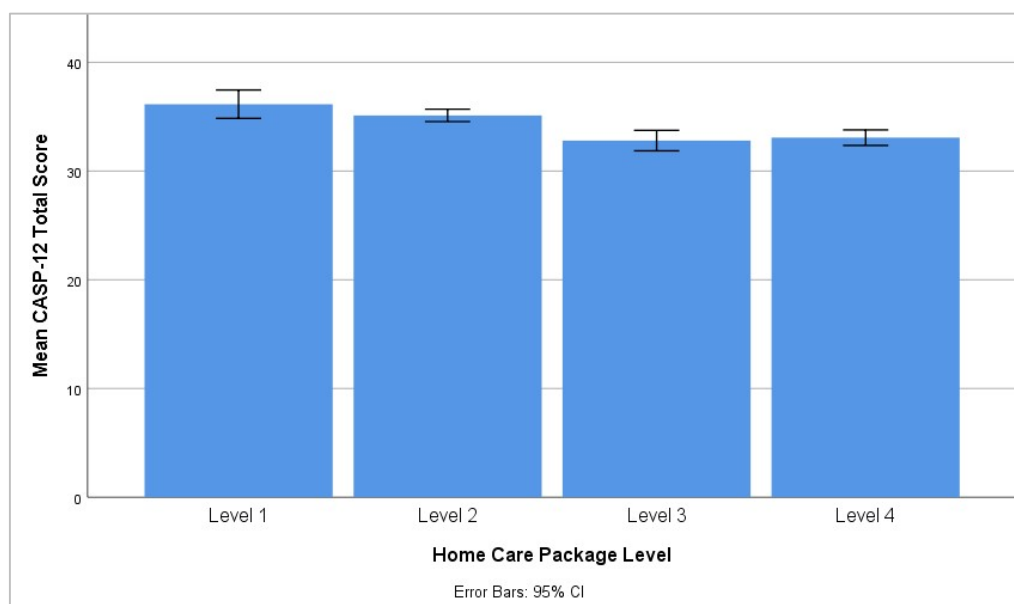
There were no significant differences in CASP-12 scores between different service provider types ($p>0.05$). HCP clients living in major cities (mean 33.5) had significantly lower CASP-12 scores than those living in inner regional (mean 35.5, $p<0.001$) and outer regional/remote/very remote areas (mean 36.0, $p=0.007$).

Similar to the GLS questionnaire, CASP-12 scores were lower when interviews were completed by proxy than when completed by the client (means 32.1 and 35.1, respectively; $p<0.001$). Further analysis to control for potential confounding factors would provide additional insight into the relationship but is beyond the scope of this report. The individual responses within the CASP-12 are shown in Table 44 in the Appendix. A significant

³⁸ Griffiths, 2020

proportion of respondents feel constrained by their age, a loss of control, unable to do what they want or don't feel full of energy. It could not be determined if this relates to poor and/or declining health, as personal information on health status was not collected.

Figure 6: Comparing quality of life scores between HCP levels



3.5.3 Social care-related quality of life

Mean SCRQoL on the ASCOT SCT-4 for HCP respondents was 0.8 (SD 0.2; median 0.8, IQR 0.7-0.9) and ranged from 0.1 to 0.8. There was a significant difference in SCRQoL between HCP levels ($p < 0.001$) with it generally decreasing as HCP level increased (Figure 7). Pairwise comparisons revealed significant differences between Level 1 and Level 3 ($p < 0.001$) clients, and between Level 2 and Level 3 clients ($p = 0.003$).

There were no significant differences in mean SCRQoL scores between service provider types ($p = 0.11$), but there was a significant difference in scores between locations (Figure 8). HCP clients living in major cities had significantly lower SCRQoL scores than those living in inner regional areas ($p < 0.001$). Consistent with the GLS and CASP-12 results, proxies (median 0.77, IQR 0.65-0.89) rated SCRQoL significantly lower than did clients (median 0.85, IQR 0.73-0.93³⁹; $p < 0.001$).

The individual responses to the ASCOT SCT-4 for HCP respondents are shown in Table 45 in the Appendix. Even though the results overall were positive, a significant minority felt they had less than adequate control over daily life (24.9%) social contact (26.3%), and occupation (35.2%).

³⁹ Reported to 2 decimal places in this instance to highlight difference

Figure 7: HCP SCRQoL scores by HCP level

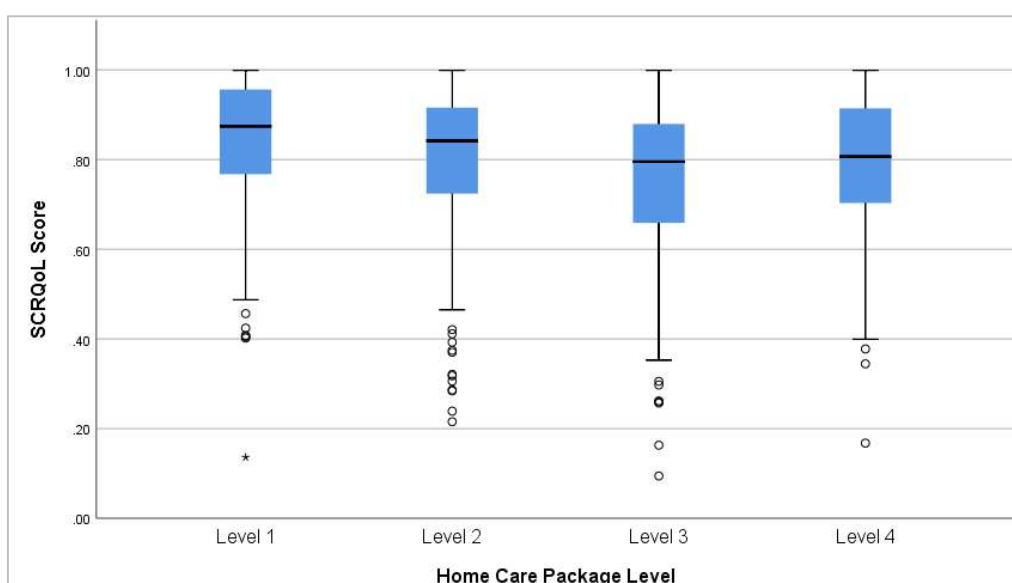
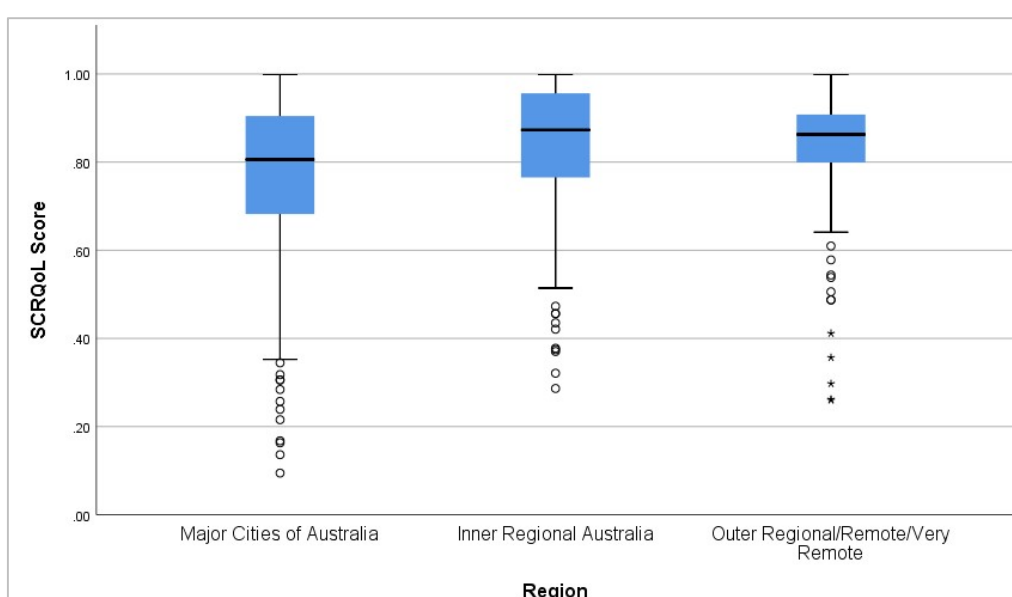


Figure 8: HCP SCRQoL by location



3.6 Concerns

The number of concerns identified by HCP respondents ranged from 0 to 34 (from a possible total of 58). HCP respondents had, on average, four concerns (SD 6.2). Half of the respondents had more than one concern (IQR 0-6).

The distribution of concerns was relatively uniform across all HCP levels (see Figure 9); however, the number of concerns significantly increased with HCP level ($p < 0.001$). The number of concerns was significantly different between Levels 1-2 (medians 0.2 and 1, IQRs 0-3 and 0-4) and Levels 3-4 (median 2, IQR 0-8 for both; pairwise $p < 0.05$).

Concerns were raised across all the different areas of HCP. The frequencies of concerns by domain are shown in Table 11. Almost half (44.9%) of the sample had concerns in the finance and administration domain, which included value for money (23.6%), service co-ordination/rostering (22.6%), monthly statements/invoicing and

transparency around fees and charges (both 18.3%). A third (33.4%) had concerns about staff, including continuity of staff (18.0%) and staff not being adequately trained (15.0%). Over one-quarter (27.3%) had concerns in the choice domain. 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 2.9%; therefore, there can be reasonable confidence in the proportions of HCP clients endorsing certain concerns.

A significantly greater number of concerns were indicated when interviews were completed by client proxies (median 2.0, IQR 0-8) compared to when clients completed the interviews (median 1.0, IQR 0-5; $p<0.001$). The incidence rate ratio (IRR) for proxies compared to clients was 1.36 (95% CI 1.10-1.70).

There were no statistically significant differences in the number of concerns for clients by provider type across HCP levels ($p=0.07$). The median number of concerns for government-run, non-profit and for-profit providers was 1.0 for all categories (IQR 0.0-6.0, 0.0-6.0 and 0.0-4.0 respectively). There were also no significant differences in number of main concerns between HCP clients who lived in major cities of Australia, inner regional Australia or in outer regional/remote or very remote areas (medians all 1.0, IQRs 0.0-7.0, 0.0-4.0, 0.0-5.8, respectively; $p=0.31$).

Figure 9: Number of concerns per HCP client by HCP level

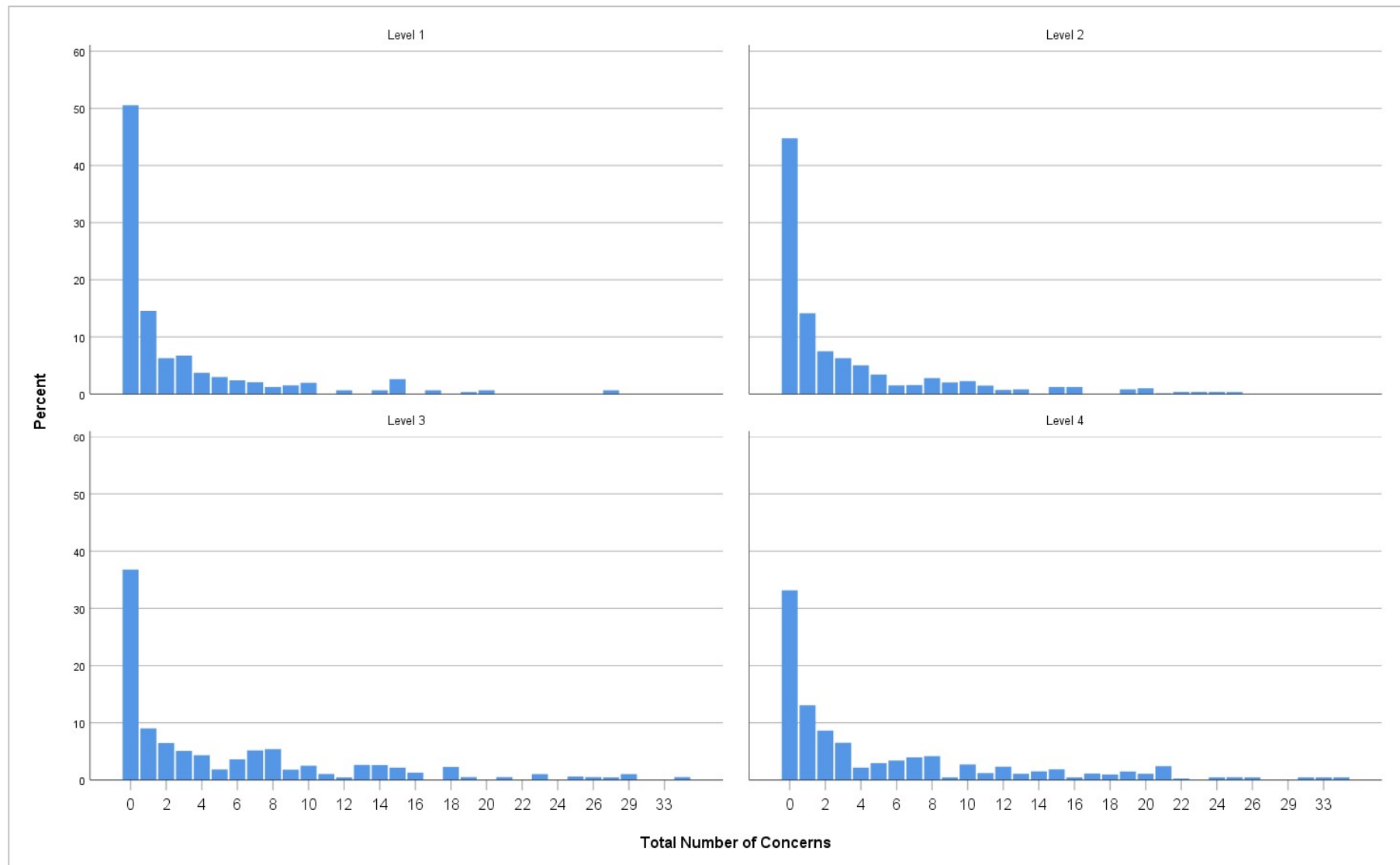


Table 11: Concerns of HCP respondents

Domain	% with a concern in this domain (95% CI)	Concerns within domain	% of total HCP sample	95% CI	
				Lower	Upper
Finance and administration	44.9 (41.3-47.1)	Value for money (e.g. fees too high)	23.6	21.1	26.0
		Service coordination/rostering	22.8	19.5	24.4
		Transparency around fees & charges	18.3	15.7	20.1
		Monthly statements/invoicing	18.3	15.6	20.0
		Inadequate correspondence or information	16.6	14.3	18.6
		Case management	16.3	13.8	18.1
		Waiting time for funds/services/reimbursements	15	13.0	17.1
		Services not tailored to my needs	12.5	10.9	14.8
		Other	9.5	7.6	11.0
		Overcharging/inaccurate charging/mistakes on invoices	1.4	0.6	1.9
Staff	33.4 (29.8-35.3)	Continuity of staff	18	15.4	19.8
		Staff not being adequately trained	15	12.7	16.9
		Poor communication between staff	11.7	9.5	13.2
		Staff not on time/cancel regularly	10.3	8.0	11.5
		Staff attitude, body language or conduct, like staff being unkind, rude or unhappy	6.6	5.1	7.9
		Staff being mismatched (e.g. not preferred gender)	6	4.4	7.1
		Other	4.9	3.6	6.0
		Staff badge/role not displayed	4.8	3.7	6.1
		Staff not being culturally sensitive (caring about my beliefs, values, spirituality, customs or religion)	2.1	1.3	2.9
		Being hurt or treated roughly by staff	1.8	1.0	2.5
		Use of restraint	0.5	0.2	1.1
Choice	27.3 (24.3-29.5)	Lack of clarity about what I was entitled to	13.5	11.6	15.6
		Were unable to negotiate costs	8.8	6.8	10.0
		Were unable to choose who provides services	8.7	6.9	10.1
		Lack of activities to choose from	8.2	6.3	9.5
		Were unable to choose when and how services are provided	8.1	6.3	9.5
		Were unable to choose required services	5.7	4.3	6.9
		Lack of choices about social interaction	5.4	3.7	6.2
		Independence not supported (e.g. not able to leave the house)	4.2	2.9	5.1
		Not included in planning/decision making	3.6	2.8	5.0
		Other	1.9	1.2	2.8
Services	20.6 (17.6-22.6)	Domestic assistance/cleaning	12.5	10.5	14.4
		Other	7.4	5.5	8.5
		Transport	5.6	4.3	7.0
		Social support/activities that are enjoyable	5.3	3.7	6.2

Domain	% with a concern in this domain (95% CI)	Concerns within domain	% of total HCP sample	95% CI	
				Lower	Upper
		Meal preparation	2.6	1.7	3.5
		Respite	1.8	0.9	2.4
		Mobility and falls prevention	6.8	4.8	8.2
Personal or medical care	15.7 (12.4-16.5)	Medical (e.g. continence, wounds, pain)	6.7	4.8	8.2
		Access to other health professionals (e.g. allied health)	5.7	4.1	7.3
		Showering, grooming or dressing	5.7	3.8	6.9
		Medication management	4.4	2.8	5.5
		Other	4.3	2.7	5.3
		General health and wellbeing management	4.1	2.9	5.6
		Access to nursing services	2.8	1.7	3.9
		Access to personal care services	2.7	1.6	3.7
		Assistance with toileting	2.2	1.1	3.0
		Assistance with eating	1.2	0.5	1.9
Equipment, home maintenance or home modification	12.8 (10.7-14.5)	Home maintenance (keeping the home & garden safe)	8.1	6.4	10.2
		Home modifications (changes to improve safety & access)	6.8	5.0	8.4
		Goods, equipment & assistive technology	6.5	5.1	8.5
		Other	3.4	2.4	4.9
Being treated with dignity and respect	11.6 (9.7-13.4)	Needs and wishes not considered	5.7	4.7	7.4
		Being treated like a child	3.8	2.7	4.8
		No individualised care plan	2.7	1.6	3.4
		Not being allowed to do certain things	2.2	1.3	2.9
		Continence pads (e.g. forced use, insufficient supply or changing)	2.1	1.3	2.9
		Shouted at by staff	1.6	1.1	2.6
		Other	1.4	0.6	1.9

3.6.1 Correlation with life satisfaction and quality

Negative correlations were observed between life satisfaction/quality of life measures and total number of concerns. A greater number of concerns was associated with lower GLS ($r=-0.28$, $p<0.001$), lower self-reported quality of life from the CASP-12 ($r=-0.29$, $p<0.001$), and lower SCRQoL ($r=-0.34$, $p<0.001$).

3.7 Main concerns

Main concerns are those identified by the respondents as their most important concerns (up to a maximum of three).

Most of the HCP sample (59.6%) reported at least one main concern, with 40.4% of the HCP sample indicating they had no main concerns. The percentage of the HCP sample with no main concerns decreased significantly as HCP level increased ($p<0.001$). The mean number of main concerns across all levels was 1.4 (SD=1.3), and the median was 1.0 (IQR=0.0-3.0). The mean number of main concerns differed significantly between HCP levels ($p<0.001$; Figure 10).

Table 12 shows the concerns most commonly deemed to be of high importance by HCP clients related to administration and finances and staff. Main concerns about administration and finance were particularly

about value for money, rostering and billing. For the staff domain, the main concerns were predominantly related to organisational factors such as staff continuity, training and punctuality, rather than factors attributable to individual staff such as attitude and body language.

Figure 10: Mean number of main concerns by HCP level

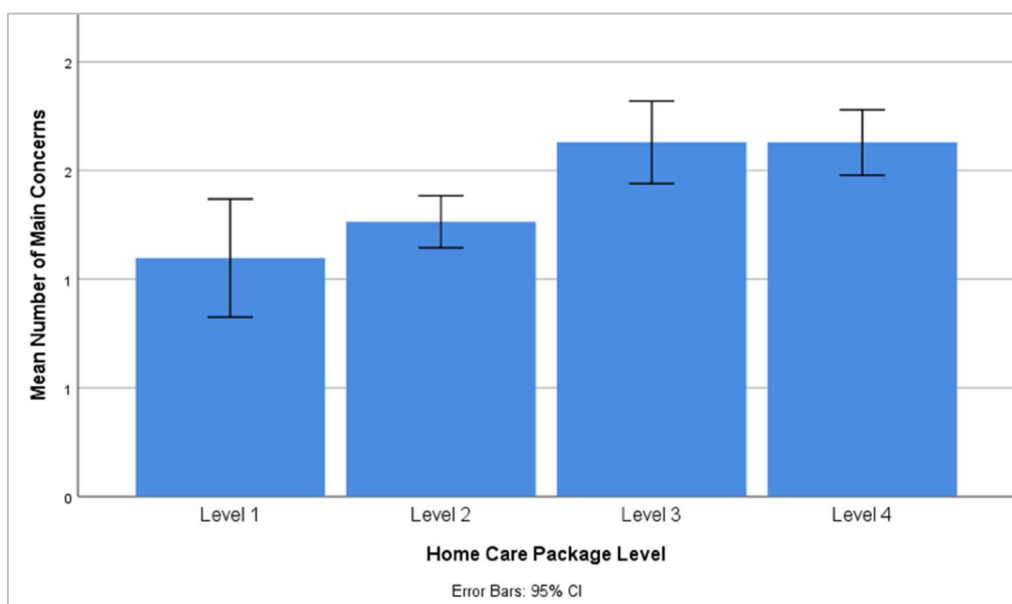


Table 12: Main concerns – HCPs

Concern	% of all main concerns	Domain
Value for money (e.g. fees too high)	8.2	Finance
Service coordination/rostering	7.1	Finance
Continuity of staff	6.3	Staff
Monthly statements/invoicing	5.4	Finance
Staff not being adequately trained	5.3	Staff
Transparency around fees & charges	4.6	Finance
Lack of clarity about what I am entitled to	4.5	Choice
Waiting time for funds/services/reimbursements	4.0	Finance
Any other concerns about finances and administration	3.9	Finance
Case management	3.6	Finance
Domestic assistance/cleaning	3.1	Services
Inadequate correspondence or information	2.9	Finance
Staff not on time/ cancel regularly	2.4	Staff
Any other concerns about services	2.4	Services
Any other concerns about home care staff	2.0	Staff
Poor communication between staff	2.0	Staff
Home maintenance (keeping the home & garden safe)	1.9	Home
Not able to choose who provides services	1.8	Choice
Lack of activities to choose from	1.7	Choice
Services not tailored to client's needs	1.7	Finance

Concern	% of all main concerns	Domain
Any other concerns about equipment, home maintenance or home modification	1.5	Home
Not able to negotiate costs	1.5	Finance
Staff being mismatched (e.g. not preferred gender)	1.5	Staff
Home modifications (changes to improve safety & access)	1.4	Home
Any other concerns about personal or medical care	1.4	Personal/medical
Transport	1.3	Services
Medication management	1.1	Personal/medical
Not able to choose when and how services are provided	1.1	Choice
Social support/activities that are enjoyable	1.1	Services
Mobility and falls prevention	1.0	Personal/medical
Accessing other health professionals (e.g. allied health)	0.9	Personal/medical
Staff attitude, body language or conduct, like staff being unkind, rude, or unhappy	0.9	Staff
Medical (e.g. continence, wounds, pain)	0.9	Personal/medical
Goods, equipment & assistive technology	0.8	Home
Needs and wishes not considered	0.8	Dignity
Not included in planning/decision making	0.7	Choice
Any other concerns about being given enough choice	0.7	Choice
Meal preparation	0.7	Services
Lack of choices about social interaction	0.6	Choice
Being treated like a child	0.6	Dignity
Not being allowed to do certain things	0.6	Dignity
Not able to choose required services	0.6	Choice
Staff badge/role not displayed	0.5	Staff
Showering, grooming or dressing	0.5	Personal/medical
Independence not supported e.g. not able to leave the house	0.4	Choice
Any other concerns about being treated with dignity and respect	0.4	Dignity
No individualised care plan	0.4	Dignity
Continence pads (e.g. forced use, insufficient supply or changing)	0.3	Personal/medical
Respite	0.3	Services
Accessing personal care services	0.3	Personal/medical
Staff not being culturally sensitive (caring about Clients beliefs, values, spirituality, customs or religion)	0.2	Staff
Use of restraint	0.1	Staff
Shouted at by staff	0.1	Staff
Being hurt or treated roughly by staff	0.1	Staff
Assistance with toileting	0.1	Personal/medical
Accessing nursing services	0.1	Personal/medical

3.7.1 Concerns related to funding issues

Nearly one quarter (22.5%) of the HCP sample's main concerns were thought by clients to be related to funding issues (Table 13), with the most common being about finances and HCP administration (Table 14). The proportion of funding-related concerns did not differ significantly between HCP levels; however, there may be a trend toward people on lower level HCPs feeling more underfunded than those with higher level HCPs. Levels 1 and 2 can be considered transition stages: to minimise the burden of long wait times for higher level HCPs, some clients who are approved for higher level HCPs may be placed on a lower level HCP as an interim option until the appropriate level HCP can be accessed. Therefore, the higher proportion of funding-related concerns in lower level HCPs may reflect either clients on interim HCPs or clients whose needs, as assessed by the Aged Care Assessment Teams, are not adequately serviced with the funding received under their current HCP level.

Table 13: Main concerns related to funding or COVID-19 by HCP level

HCP Level	% of main concerns related to funding	% of main concerns related to COVID-19
Level 1	31.0	13.3
Level 2	23.3	10.4
Level 3	21.3	13.4
Level 4	18.8	11.0
All levels	22.0	11.5

Differences in the proportion of funding-related issues by client age may also reflect higher level of care needs for the youngest and oldest people accessing HCP services. Half of the main concerns identified by clients aged 55-64 were indicated to be funding-related, while this was the case for 20.0% to 22.5% of main concerns for people aged 65-94. This increases to 28.8% of main concerns for people aged over 95. No difference was observed when considering whether the client or a proxy completed the interview.

No differences in funding-related main concerns were observed between different HCP provider types or between the different remoteness areas.

While funding issues were defined and explained to respondents as being reflective of inadequate government funding allocated to the client, not management/administration of funding, some interviewer notes suggest that this concept was not easily understood by respondents. Some respondents thought this reflected funding issues to the sector, for example, that providers may need more funding to employ more staff or provide more working hours to employed staff to improve continuity of care. Others interpreted this to mean relating to administrative fees. The variability in respondents' understanding of the concept may be indicative of the complexity of the HCP system and how difficult it is to navigate for clients and anyone supporting them.

Table 14: Main concerns related to funding for HCP clients

Domain	% of all funding-related concerns
Finances & administration	47.0
Choice	18.2
Services	9.6
Personal & medical care	9.1
Staff	7.5
Dignity & respect	4.7
Equipment, home maintenance & modifications	4.0

3.7.2 COVID-19-related concerns

Of all the identified main concerns by HCP clients, 11.5% were attributed by clients to the COVID-19 pandemic. The percentage was similar across HCP levels (Table 13) and there were no differences between different provider types and remoteness regions.

Across the entire HCP sample, the most common main concerns that were a result of the COVID-19 pandemic related to finances and administration, and choice (Table 15). Free-responses indicated generally that clients either felt there was restricted availability of services by providers, or had chosen to limit services received to minimise contact with others. Clients noted increased levels of understaffing or inconsistency of care, or providers requesting that clients reduce their service hours during the pandemic. Clients were also limited in the activities they could undertake, leading some to feel lonely and isolated.

Table 15: Concerns related to COVID-19 for HCP clients

Domain	% of concerns due to COVID-19
Finances & administration	24.6
Choice	19.5
Staff	16.8
Services	15.4
Personal & medical care	12.0
Equipment, home maintenance & modifications	7.2
Dignity & respect	4.6

3.8 Reporting of concerns

3.8.1 Complaints

About two thirds (69.3%) of the main concerns raised by HCP clients were reported or discussed with others (i.e. became complaints), regardless of whether this was done officially (e.g. to staff or management) or unofficially (e.g. to family or friends). See Figure 11 for a flow diagram of the key results of this part of the questionnaire and Table 46 in the Appendix for further details about which main concerns became complaints, how they were reported and if they were resolved.

The number of concerns reported did not differ significantly between Level 1-3 clients, but was higher among Level 4 clients. Rates of sharing concerns with others also did not differ across provider types or remoteness.

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

1. Service coordination/rostering (8.2%)
2. Continuity of staff (6.8%)
3. Value for money (e.g. fees too high) (6.2%)
4. Staff not being adequately trained (5.7%)
5. Monthly statements/invoicing (5.7%)

Only main concerns that represented greater than 5.0% of complaints are listed above; an expanded list is shown in Table 46 in the Appendix. When surveys were completed by a proxy, the respondents were more likely to indicate that clients had spoken to someone about their main concerns than when surveys were completed by clients themselves (73.3% of proxies vs 66.9% of clients). This is not unexpected: representatives may primarily manage HCP services on behalf of clients who require high levels of support. Representatives may also include themselves as someone to whom the client had spoken about their concerns. Although representatives were asked to answer the survey from the perspective of the client, the higher level of reporting could reflect concerns noticed and acted upon by representatives in cases where the client lacked

the insight or capacity to take action in response to the concern, or where services are meant to support the representative rather than the client (e.g. respite). Despite this, clients who completed the interviews themselves were more likely to say a complaint had been made officially, compared to interviews completed by proxies (59.5% vs 49.7%; $p < 0.001$).

3.8.2 Unreported concerns

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

1. Value for money (e.g. fees too high) (12.6%)
2. Lack of clarity about what I am entitled to (6.4%)
3. Continuity of staff (5.1%)

See Table 46 in the Appendix for an expanded list.

Respondents were able to give multiple reasons why each concern was not reported. The main reasons HCP clients did not share their concerns with others were that they did not think anything would change (17.0%), that they thought their concern was too minor (15.4%), and/or that they did not want to be a nuisance (14.3%). The proportion of concerns that were not reported was relatively high for the following reasons: because respondents did not know to whom their concern should be reported (12.0%), did not know how to report (5.8%), did not have capacity to report (5.8%), and/or feared repercussion (1.3%).

Of the main concerns not shared with others because clients did not think anything would change, the most frequent (as a share of all such concerns) were:

1. Value for money (e.g. fees too high) (30.7%)
2. Transparency around fees & charges (16.3%)

The main concerns unreported because clients felt that they were too minor (as a share of all such concerns) were most frequently:

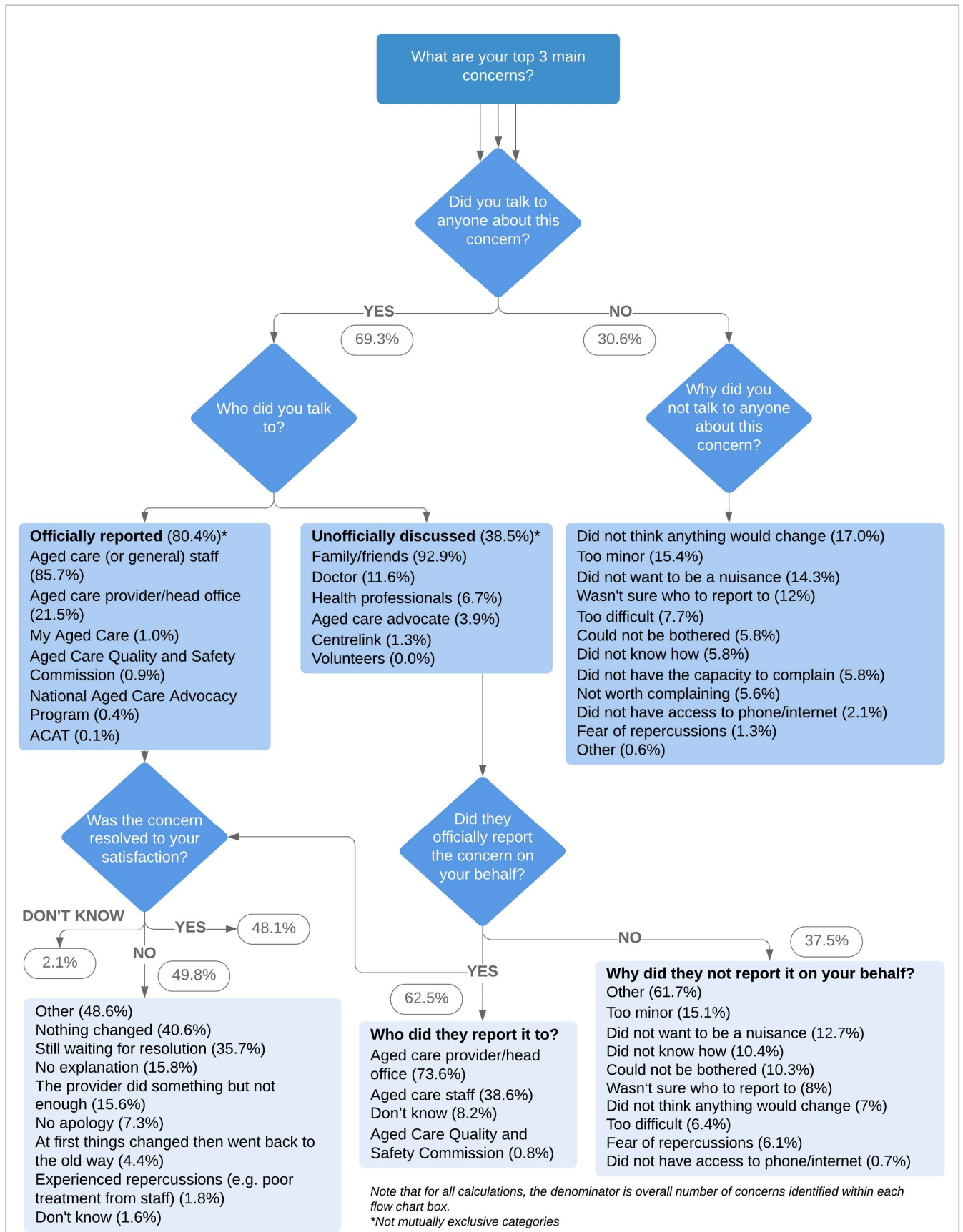
1. Value for money (e.g. fees too high) (13.3%)
2. Monthly statements/invoicing (9.8%)
3. Staff not being adequately trained (9.2%)
4. Service coordination/rostering (8.5%)
5. Waiting time for funds/services/reimbursements (7.6%)
6. Continuity of staff (5.3%)

The main concerns not shared with others because clients did not want to be a nuisance tended to be (as a share of all such concerns):

1. Value for money (e.g. fees too high) (19.3%)
2. Service coordination/rostering (11.4%)
3. Staff not being adequately trained (9.2%)
4. Home maintenance (keeping the home & garden safe) (7.6%)
5. Domestic assistance/cleaning (5.9%)
6. Inadequate correspondence or information (5.6%)

Only concerns with a proportion greater than 5.0% are listed above. See Appendix Table 47 for an expanded list.

Figure 11: Flow chart of responses regarding reporting and resolution of concerns for HCP clients



3.8.3 Recipients of complaints

For each main 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 occurred for 80.4% of the complaints, while 38.5% were shared unofficially (18.9% of complaints were shared both officially and unofficially). No significant differences in official reporting were observed between HCP Levels 1-4 (53.1%, 55.5%, 51.5% and 59.3% respectively). No significant difference was observed in the likelihood that concerns were officially reported between the remoteness regions across all HCP levels ($p=0.32$). HCP clients being serviced by government-run providers were most likely to report their complaints officially (62.0% of all complaints in this provider type), followed by those with non-profit (57.3%) and for-profit (47.7%) providers ($p=0.007$).

Table 16 shows that the recipient of complaints was similar across the HCP levels. Most complaints were made to aged care staff (70.5%, for example, home care workers) or to their provider/head office (18.7%). A very small proportion (typically less than 1%) were reported through government channels such as the ACQSC and My Aged Care. A little under a third of concerns were discussed with family and friends. Small proportions of concerns were also discussed with doctors, health professionals, volunteers and aged care advocates. Compared to the other two service groups (CHSP and residential respite), HCP clients spoke to a wider range of people and groups about their concerns, including My Aged Care or Aged Care Assessment Teams (ACAT). See Figure 11 for the proportions of complaints as a share of whether they were reported officially or unofficially.

Table 16: Sharing of concerns – HCP clients by level

Who clients reported to	% of complaints by HCP level				
	Level 1	Level 2	Level 3	Level 4	Total
Staff (aged care or any general staff)	67.7	71.8	65.6	72.4	70.5
Family/friend	28.1	31.9	31.9	31.7	31.6
Provider	19.4	17.4	22.7	17.5	18.7
Doctor	3.2	5.2	2.4	5.6	4.6
Health professionals	1.6	4.1	3.8	2.5	3.3
Aged care advocate	0	1.0	0	3.1	1.5
Other^	0	2.5	1.4	0.6	1.5
Volunteers	0	1.6	0.5	0.8	1.0
My Aged Care	1.5	1.0	0.5	0.8	0.9
Aged Care Quality and Safety Commission	0	0.5	0.5	1.4	0.8
National Aged Care Advocacy Program	1.6	0.5	0	0.3	0.4
Centrelink	3.1	0	0.5	0	0.3
ACAT	1.6	0	0	0	0.1

NB highlighted rows indicate avenues considered in this report to be 'official reporting'

^'Other' responses included local politicians and lawyers, visitors, other residents (referring to retirement village residents rather than aged care residents) or contracted workers (e.g. home maintenance workers).

3.8.4 Complaints on behalf of clients

Of the main concerns that were only shared with others in unofficial capacities, 62.5% were then officially reported on behalf of the client. Most of the concerns that were reported on behalf of clients were to the provider head office (73.6%). Next most common was reporting to staff (38.6%). A small proportion of

concerns were reported to the ACQSC (0.8% of concerns reported on behalf of clients), and 8.0% were reported but clients did not know to whom.

Concerns were most likely to be reported by family/friends on behalf of clients (64.9%) and the likelihood increased with higher HCP levels (from Levels 1-4: 35.1%, 61.8%, 66.6%, 65.3%). Concerns were reported by health professionals on behalf of clients in nearly half (49.6%) of cases, and by doctors in 19.7% of cases. Clients often did not know why complaints were not reported on their behalf by doctors or health professionals. Although only a small proportion of concerns were discussed with volunteers or aged care advocates, none of those concerns were then reported on behalf of clients.

The most common reason that concerns were not reported on behalf of clients was 'other' (61.7% of the concerns not reported on clients' behalf). Free responses indicated a variety of reasons. The most common responses were that it was not anyone else's place to lodge a complaint on the client's behalf, they expected nothing would be done about it, or that nothing could be done due to COVID-19. Some clients indicated that the concern occurred very recently and they either had not yet reported it or they were waiting to see if the issue would re-occur. Some clients had opted to change providers rather than address their complaints.

The next most common reason was that they believed the concerns were 'too minor' (15.1% of the concerns not reported on clients' behalf).

3.9 Resolution of official complaints

Of the main concerns that were officially reported, nearly half (49.8%) were not resolved to HCP clients' satisfaction. This did not differ significantly between HCP levels, proxy or HCP client interviews, nor did it differ across provider types or remoteness.

The primary reasons cited for official complaints being unresolved were that nothing changed (40.6%) or that the client was still waiting for resolution (35.7%). In 15.6% of cases, the client said something had been done but not enough, while in 4.4% of cases there had been change at first but then things went back to the old way. Repercussions such as poor treatment from staff were experienced by clients for 1.8% of official complaints. There were a high number of unprompted 'other' reasons given in the interviews, which included understaffing, insufficient funding (both in the HCP and broader aged care system), poor communication from providers, that the HCP client had changed providers (possibly as a result of the concern), or that it wasn't possible for the concern to be resolved.

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

1. Service coordination/rostering (8.4%)
2. Other concerns about finances and administration (7.0%)
3. Monthly statements/invoicing (6.5%)
4. Value for money (e.g. fees too high) (6.5%)
5. Continuity of staff (5.5%)

Whether complaints were reported to head office or to staff (by the client or someone on their behalf) did not make a difference to the likelihood of satisfactory resolution; 47.6% of complaints were resolved satisfactorily in both cases. Complaints raised to the ACQSC were resolved to clients' satisfaction 55.8% of the time, which is consistent with the ACQSC's own report that 57% of complaints were resolved to complainants' satisfaction across all aged care services in the early resolution phase⁴⁰. The ACQSC's report also states that 91% of complaints were finalised within 90 days, indicating clients can have a considerable wait for a resolution regardless of whether the resolution is satisfactory or not.

⁴⁰ Aged Care Quality and Safety Commission, 2019

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

1. Continuity of staff (10.1%)
2. Service coordination/rostering (9.0%)
3. Monthly statements/invoicing (7.7%)
4. Staff not being adequately trained (7.1%)
5. Value for money (e.g. fees too high) (6.3%)
6. Transparency around fees & charges (5.2%)

See Table 47 in the Appendix for a full list of the individual concerns and rates of resolution, as only those with a proportion greater than 5.0% are listed above. It is interesting to note that some individual concerns appear in both lists of concerns that were most likely to be unresolved and satisfactorily resolved; this highlights the complexities involved in resolving some complaints, such as continuity of staff, service coordination/rostering and value for money. This survey did not collect information about the actions taken by HCP providers to resolve complaints and it is therefore not known why residents felt those complaints were resolved to their satisfaction.

Official complaints about staff had the highest rate of satisfactory resolution (68.0%) as shown in Table 17. Complaints regarding finances and administration were next most likely to be resolved satisfactorily (45.1%). The proportion of complaints officially reported by clients and by others on their behalf was similar in these two domains, indicating complaints about staff might be easier to resolve than those about finances and administration, which may reflect more systemic issues within the sector that are not easily resolvable at the level of the individual client. Concerns about being treated with dignity and respect were least likely to be discussed with others or reported by clients, and were also the least likely to be resolved to clients' satisfaction when they were reported officially.

Table 17: Sharing, reporting and resolution of concerns by domain – HCP clients

Domain of concern	% shared with anyone	% of concerns in each domain that were officially reported		% of concerns in each domain officially reported that were resolved
		By client	On behalf of client*	
Staff	78.0	59.1	61.7	68.0
Services	70.7	52.6	84.0	42.9
Equipment, home maintenance & modifications	70.2	57.1	7.0	32.4
Finances & administration	69.6	59.2	64.1	45.1
Personal & medical care	66.7	46.2	47.4	36.1
Choice	58.3	49.5	61.1	38.1
Dignity and respect	56.3	41.7	25.0	26.7

* That client did not officially report themselves

4 Commonwealth Home Support Programme respite results

4.1 Recruitment

A total of 155 interviews were completed with the CHSP respite group (Table 18). A majority (76.8%) were completed by proxies and two (1.3%) required an interpreter (Greek or Italian).

Table 18: Number of completed CHSP respite interviews by remoteness and provider type

Location	n
Major Cities of Australia	
Non-Profit	65
For-Profit	13
Government	17
Inner Regional Australia	
Non-Profit	23
For-Profit	5
Government	6
Outer Regional/Remote/Very Remote	
Non-Profit	16
For-Profit	5
Government	5
Total n	155

4.2 Demographics

Around two-thirds of the CHSP respite clients were female and one third male (unweighted percentages of 64.3% and 38.7% respectively; Table 19). Most were aged between 75 and 94 years. The majority (79.1%) of respondents had been receiving CHSP respite services for more than one year. Nearly three-quarters of respondents reported using flexible CHSP respite services and nearly 40.0% used centre-based services. Only 10.0% reported using cottage-based services.

Table 19: Demographic characteristics of CHSP respite respondents, n=155

Characteristic	n (unweighted)	Unweighted %	Weighted %
Sex			
Female	95	64.3%	61.3%
Male	60	38.7%	38.7%
Age (years)			
55-64	<5	1.9%	2.1%
65-74	26	16.8%	17.0%
75-84	59	38.1%	39.0%
85-94	54	34.8%	34.3%
95+	10	6.5%	5.6%
Prefer not to say	<5	1.9%	1.6%
CHSP Respite Duration			
Less than 6 weeks	<5	1.3%	1.5%
6 weeks-6 months	9	5.8%	6.3%
6-12 months	19	12.3%	11.7%
1+ year	123	79.4%	79.1%
Don't know	<5	1.3%	1.4%

Characteristic	n (unweighted)	Unweighted %	Weighted %
CHSP Respite Type*			
Flexible	114	73.5%	73.0%
Centre-based	61	39.4%	39.9%
Cottage	19	12.3%	11.6%
Unsure	<5	1.9%	2.1%

*Total adds up to >155 as more than one type could be selected

4.3 Quality of care

In general, the results from the Quality of Care questionnaire indicate around half or more of the CHSP respite clients were only partially satisfied with the care they received and a significant minority were highly unsatisfied.

The majority of CHSP respite clients reported that they are ‘always’ treated with respect and dignity (75.9%) and 20.5% felt they were ‘mostly’ treated this way. In the other domains, the share of ‘always’ satisfied was between 40-55% with around 30% ‘mostly’ satisfied. The exceptions were in the complaints domains where results were much less positive. For example, nearly half (46.0%) of CHSP respite respondents reported ‘never’ knowing how to lodge a complaint, and 26.0% ‘never’ felt comfortable in lodging a complaint. In addition, 28.1% of respondents felt that they were only sometimes (or less often) confident that appropriate action would be taken when they made a complaint (Figure 12 and Table 48 in the Appendix).

In addition to the results for complaints, there was a large minority who felt that quality of care was significantly lacking in other domains. Around 23.5% said they only ‘never’, ‘rarely’ or ‘sometimes’ received the support to make their own decisions about the care and services they receive, 14.5% said they only sometimes (or less often) received care from aged care staff who have the appropriate skills and training, and 30.5% said they only sometimes (or less often) received support to maintain their social relationships and connections with the community.

When grouping responses by individual respondent, 14.1% were ‘always’ satisfied in all areas, 35.2% were at least ‘mostly’ satisfied in all areas (not including ‘always’) and 50.7% were ‘sometimes’ or less often satisfied in an area (Figure 13).

Figure 12: Quality of Care – CHSP respite clients: percentage by response category

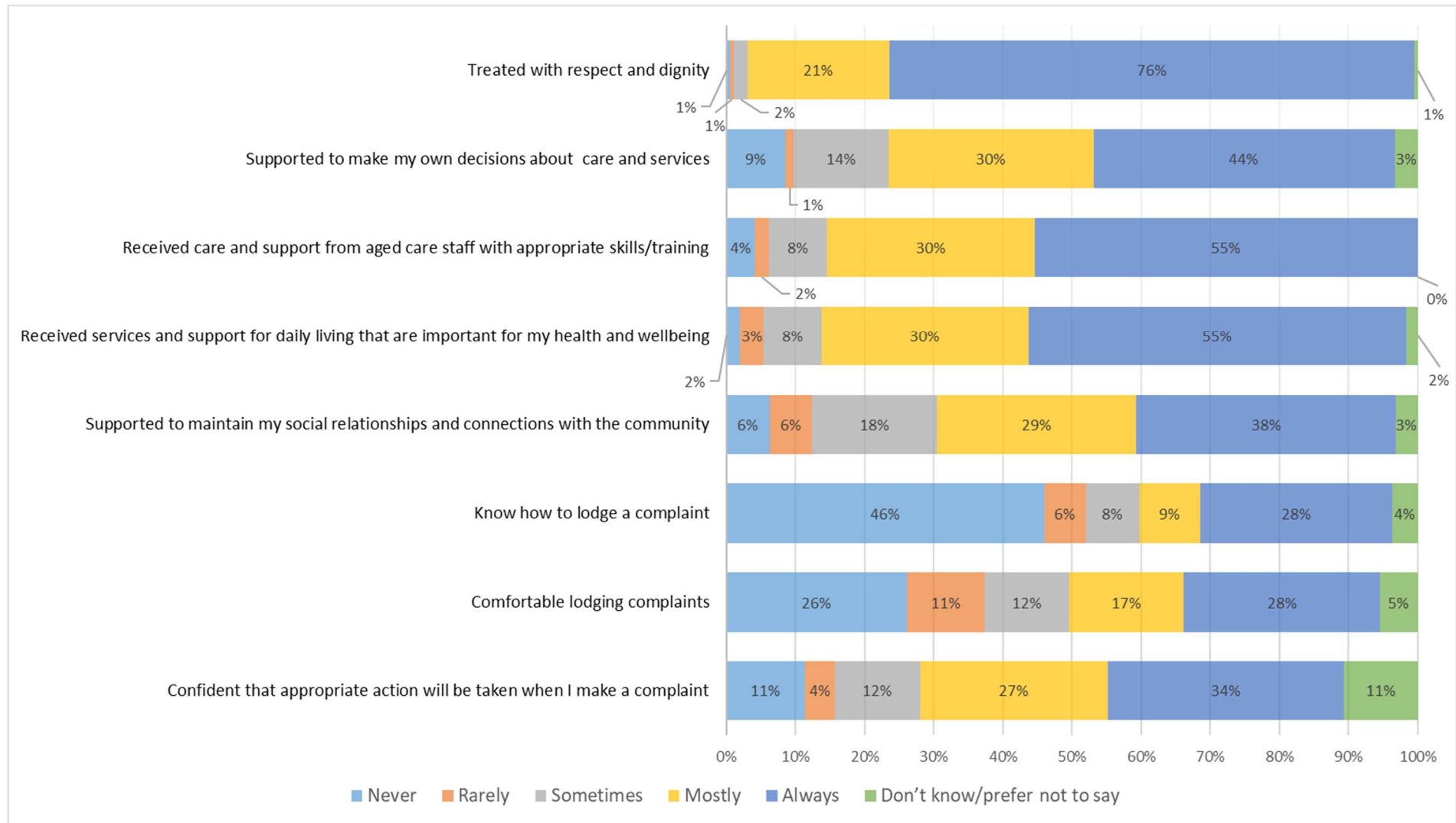
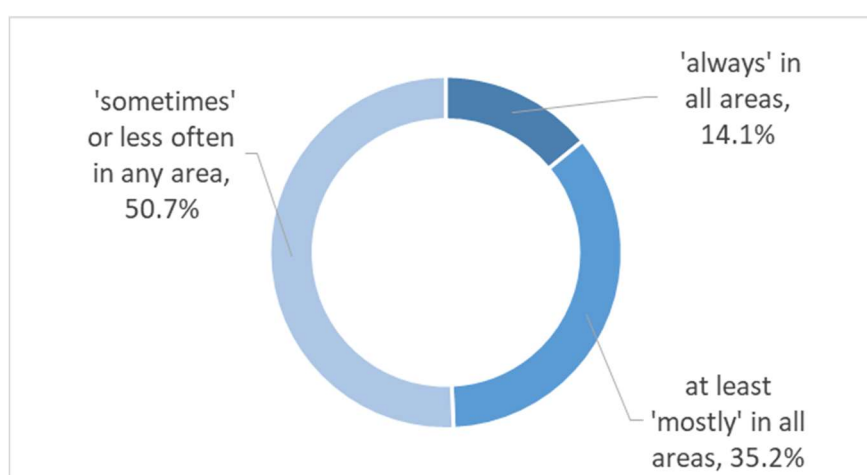


Figure 13: Quality of Care – CHSP respite clients: percentage across areas



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

4.4 Life satisfaction and quality

4.4.1 General life satisfaction

GLS scores ranged from 0.0-10.0 (where 10 is the highest GLS). Mean GLS for all CHSP respite clients at the time of the interviews was 6.5 (SD 2.2) and the median was 7.0 (IQR 5.0-8.0). When asked to rate their satisfaction with life before the COVID-19 pandemic, the group mean was 6.9 (SD 2.1) with a median of 7.0 (IQR 5.0-8.0). The average reduction in GLS when comparing the pre COVID-19 score with the GLS during COVID-19 was 0.3, and this change was significant ($p < 0.001$).

The respondents serviced by government providers (median 6.0, IQR 5.0-7.0) had significantly lower GLS compared to those from non-profit (median 7.0, IQR 5.0-8.0; $p < 0.001$) and for-profit (median 7.0, IQR 5.0-8.0; $p = 0.006$) providers. There were no differences in GLS between different categories of remoteness.

4.4.2 General quality of life

Total CASP-12 scores for CHSP respite clients ranged from 16.0 to 48.0 (where 48.0 is the highest self-reported quality of life), with a mean of 31.7 (SD 6.5) and a median of 32.0 (IQR 27.0-36.0). Proxies reported significantly lower CASP-12 scores (mean 30.6, SD 6.5) than clients themselves reported (mean 34.8, SD 5.5; $p < 0.001$). There were no differences across provider types or remoteness areas.

The individual responses for the CASP-12 are shown in Table 49 in the Appendix. A high proportion of respondents feel constrained by their age, a loss of control, left out of things, unable to do what they want, lack energy 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.

4.4.3 Social care-related quality of life

SCRQoL scores on the ASCOT SCT-4 for all CHSP respite clients ranged from 0.3 to 1.0 (where 1.0 indicates the highest SCRQoL). Mean SCRQoL was 0.7 (SD 0.2) and the median was 0.7 (IQR 0.6-0.8). Proxies reported significantly lower SCRQoL scores (mean 0.7, SD 0.2) than clients themselves reported (mean 0.8, SD 0.1; $p < 0.001$).

The SCRQoL scores were significantly better for clients with non-profit providers (mean 0.74, SD 0.17) compared to government providers (mean 0.69, SD 0.17⁴¹; $p = 0.007$), although the size of the difference was

⁴¹ Reported to 2 decimal places in this instance to highlight difference

small. No difference was observed when comparing for-profit providers (mean 0.7, SD 0.1) with non-profit and government providers ($p>0.05$; Figure 14). Clients living in inner regional areas had significantly better SCRQoL scores (mean 0.8, SD 0.1) compared to those living in major cities (mean 0.7, SD 0.2; $p=0.02$). Clients living in outer regional areas had a mean SCRQoL score slightly higher than those living in inner regional areas but the standard deviation was larger (mean 0.8, SD 0.2), so the difference to major cities was not statistically significant ($p=0.054$; Figure 15).

The individual responses to the ASCOT SCT-4 for CHSP respite respondents are shown in Table 50 in the Appendix. Even though the results overall were quite positive, a significant proportion felt they had less than adequate control over daily life (44.0%), social contact (40.8%), or occupation (49.3%).

Figure 14: SCRQoL scores by provider type – CHSP respite clients

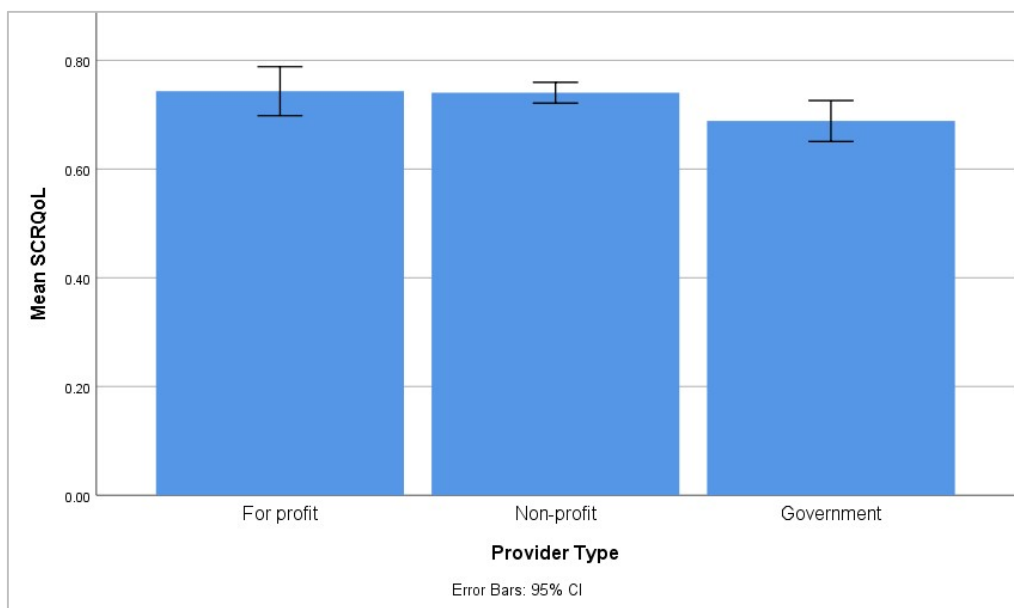
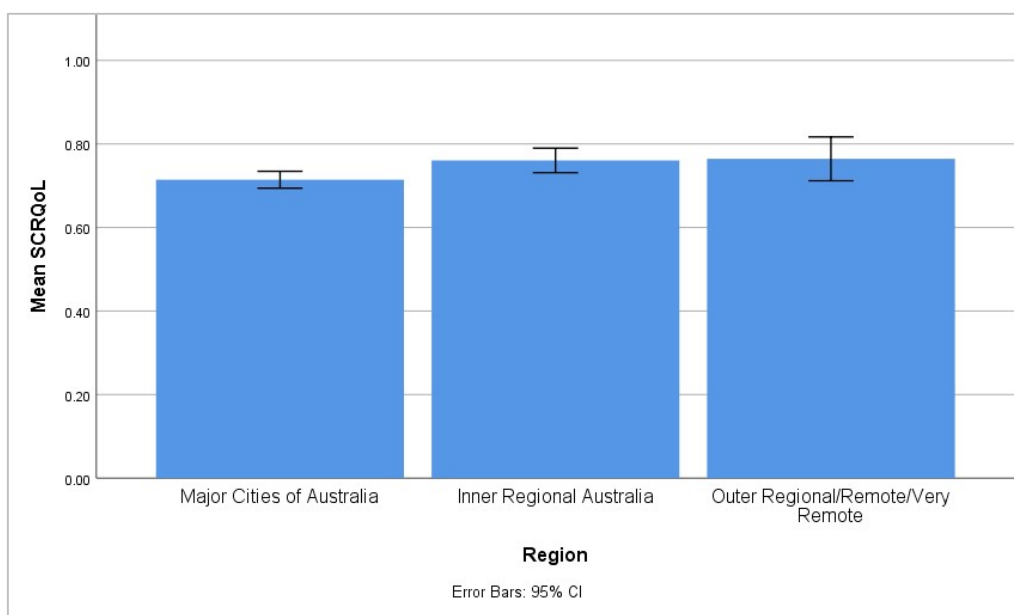


Figure 15: SCRQoL scores by location – CHSP respite clients



4.5 Relief for carers

When proxies were asked about how helpful CHSP respite services are in providing relief for them as a carer, over three-quarters (78.5%) of respondents indicated that the services helped ‘a great deal’, or were ‘much’ help (Table 20). Only 5% found CHSP respite services to be of little or no help. CHSP respite services are most often accessed in the form of ‘flexible’ respite, where an aged care worker provides a short period of respite in the client’s own home. CHSP respite services may be limited and difficult to access, and it is possible that this form of respite is insufficient for many clients given that nearly 20% of representatives said that these were ‘somewhat’ or less helpful to them. Residential respite services appear to be more helpful and provide more relief for carers.

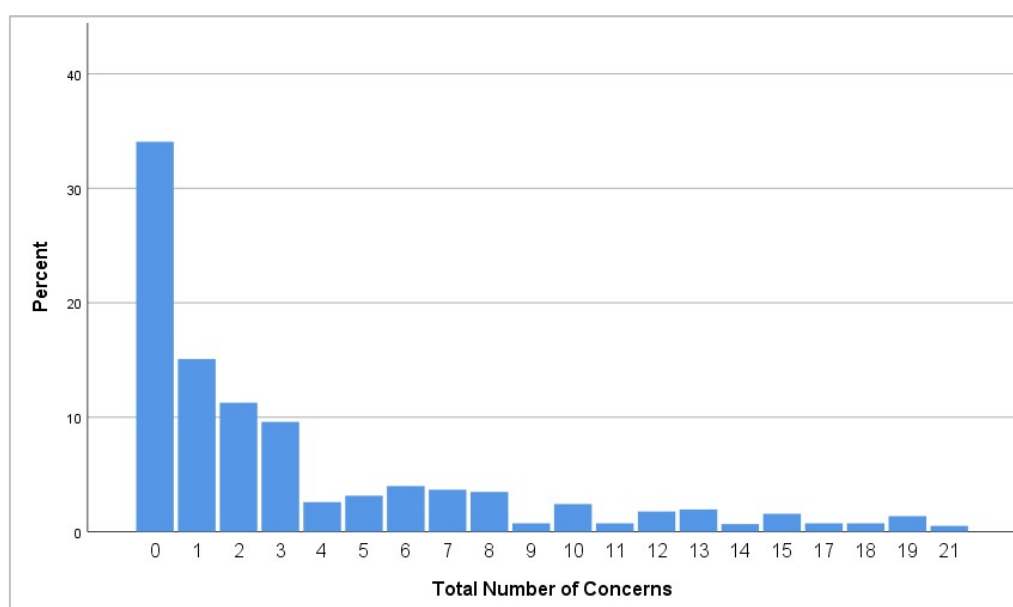
Table 20: Degree to which respite services helped in relieving the carer

Degree to which respite services relieved carer	CHSP respite (%)	Residential respite (%)
Not at all	0.0	0.5
Little	5.0	3.2
Somewhat	14.7	7.5
Much	17.5	19.3
A great deal	61.0	69.5
Don’t know	0.9	0.0
Prefer not to say	0.9	0.0

4.6 Concerns

The number of concerns identified by CHSP respite respondents ranged from 0 to 21 (from a possible total of 55) (Figure 16). The mean number of concerns was 3.5 (SD 4.7), and the median was 2.0 (IQR 0.0-5.0).

Figure 16: Number of concerns per CHSP respite respondents



The most common concerns for CHSP respite respondents related to the finance and administration of their services (46.9% of all concerns), which included value for money (25.7%), service coordination/rostering (25.6%) and transparency around fees and charges (20.0%). Concerns about staff (30.6%) tended to be about lack of continuity (16.2%) and training (15.3%). The most common concern in the services domain (29.9%) was loneliness and boredom. In choice (29.1%), 10% or more of clients had concerns about not being able to

choose when and how services are provided, who provides them, and the lack of clarity about their entitlement or activities to choose from. See Table 21 for the full list of identified concerns. The 95% confidence intervals around those proportions were moderate in overall size, averaging 5.2%.

There was no significant difference in the number of concerns identified if the interview was completed by the client or by their proxy ($p=0.55$).

No significant difference was observed in the number of concerns between the different provider types ($p=0.08$). The median number of concerns was 0.0 (IQR 0.0-3.0) in for-profit, 2.0 (IQR 0.0-4.0) in non-profit, and 2.0 (IQR 0.0-7.0) in government-run organisations. There was also no significant difference observed in number of concerns between the different remoteness areas ($p=0.40$). The median number of concerns was 2.0 (IQR 1.0-5.0) in outer regional/remote/very remote, 2.0 (IQR 0.0-6.0) in major cities and 1.0 (IQR 0.0-3.0) in inner regional areas.

Table 21: Concerns of CHSP respite respondents

Domain	% with a concern in this domain (95% CI)	Concerns within domain	% of total CHSP sample	95% CI	
				Lower	Upper
Finance and administration	46.9 (42.0-51.4)	Value for money (e.g. fees too high)	25.7	22.1	30.4
		Service coordination/rostering	25.6	21.5	29.7
		Transparency around fees & charges	20.0	16.5	24.1
		Inadequate correspondence or information	17.5	14.2	21.3
		Services not tailored to my needs	14.1	11.1	17.6
		Other	4.4	2.8	6.6
Staff	30.6 (26.7-35.4)	Continuity of staff	16.2	13.3	20.4
		Staff not being adequately trained	15.3	12.3	19.1
		Staff not on time/cancel regularly	10.4	8.0	13.8
		Poor communication between staff	9.5	7.0	12.5
		Staff being mismatched to my preferences (e.g. not preferred gender)	7.6	5.6	10.7
		Staff badge/role not displayed	4.5	2.9	6.9
		Other	4.5	2.8	6.6
		Staff attitude, body language or conduct, like staff being unkind, rude, or unhappy	4.4	6.0	11.2
		Staff not being culturally sensitive (caring about my beliefs, values, spirituality, customs or religion)	4.1	2.6	6.4
		Understaffed	0.9	0.3	2.2
		Use of restraint	0.8	0.3	2.2
		Being hurt or treated roughly by staff	0.7	0.2	1.8
Services	29.9 (25.8-34.5)	Loneliness and boredom	16.8	13.6	20.6
		Transport	9.9	7.6	13.3
		Being connected with the community	8.1	6.2	11.5

Domain	% with a concern in this domain (95% CI)	Concerns within domain	% of total CHSP sample	95% CI	
				Lower	Upper
		Meal preparation	7.4	5.2	10.1
		Activities that are enjoyable	6.9	4.8	9.6
		Other	2.2	1.0	3.8
Choice	29.1 (25.0-33.5)	Not able to choose when and how services are provided	12.7	9.8	16.1
		Lack of activities to choose from	11.4	8.8	14.8
		Lack of clarity about what I am entitled to	11.2	8.6	14.6
		Not able to choose who provides services	10.7	8.0	13.8
		Not able to choose required services	8.0	5.6	10.7
		Lack of choices about social interaction	7.4	5.2	10.1
		Independence not supported e.g. not able to leave the house	5.7	3.9	8.3
		Other	4.4	2.8	6.6
		Not included in planning/decision making	3.8	2.2	5.8
Respite environment	23.5 (15.8-32.2)	Other	13.8	7.6	20.8
		The security of the respite facility	3.9	1.5	9.9
		Feeling safe in the respite facility	3.9	1.5	9.9
		Privacy	3.4	0.9	8.4
		Noise	3.4	0.9	8.4
		Cleanliness and maintenance of the respite facility	3.1	0.9	8.4
Personal or medical care	11.0 (7.4-15.2)	Showering, grooming or dressing	5.6	3.2	9.1
		Mobility and falls prevention	3.9	1.9	6.9
		Assistance with toileting	2.5	1.1	5.2
		Medical (e.g. continence, wounds, pain)	2.2	0.8	4.6
		Other	2.2	0.8	4.6
		Assistance with eating	1.2	0.4	3.4
Dignity and respect	9.9 (7.4-13.0)	Being treated like a child	4.8	3.1	7.2
		Continence pads (e.g. forced use, insufficient supply or changing)	3.5	2.0	5.5
		Needs and wishes not considered	2.6	1.4	4.4
		Not being allowed to do certain things	2.0	1.0	3.8
		Being shouted at by staff	0.7	0.2	1.8
		Other	0.5	0.1	1.5

4.6.1 Correlation with life satisfaction and quality

Having a greater number of concerns was associated with lower current GLS scores ($r=-0.12$, $p=0.02$). Negative correlations were also observed between the number of concerns and CASP-12 ($r=-0.16$, $p=0.003$) and SCRQoL scores for CHSP clients ($r=-0.20$, $p<0.001$).

4.7 Main concerns

About two thirds of CHSP respite clients (65.9%) identified at least one main concern out of a possible total of three: 34.1% had no main concerns, 15.2% identified one main concern, 12.2% identified two, and 38.5% identified three main concerns. The mean number of main concerns was 1.6 (SD 1.3), and the median was 2.0 (IQR 0.0-3.0).

Table 22 shows the concerns most frequently reported to be of high importance to CHSP respite clients, and were predominately related to the value and transparency of fees, needing clarity on what they were entitled under the program, loneliness and boredom, and staffing issues.

Table 22: Main concerns – CHSP respite

Concern	% of all main concerns	Domain
Value for money (e.g. fees too high)	9.1	Finance
Lack of clarity about what I am entitled to	8.0	Choice
Transparency around fees & charges	7.2	Finance
Any other concerns about finances and administration	5.9	Finance
Loneliness and boredom	5.4	Services
Staff not being adequately trained	5.4	Staff
Continuity of staff	5.0	Staff
Any other concerns about services	4.5	Services
Inadequate correspondence or information	4.3	Finance
Staff not on time/cancel regularly	4.2	Staff
Any other concerns about being given enough choice	3.2	Choice
Staff attitude, body language or conduct, like staff being unkind, rude, or unhappy	3.1	Staff
Meal preparation	2.8	Services
Staff being mismatched to my preferences (e.g. not preferred gender)	2.6	Staff
Services not tailored to my needs	2.5	Finance
Activities that are enjoyable	2.4	Services
Not able to choose when and how services are provided	2.0	Choice
Lack of activities to choose from	2.0	Choice
Continence pads (e.g. forced use, insufficient supply or changing)	1.8	Dignity
Poor communication between staff	1.7	Staff
Any other concerns about home care staff	1.7	Staff
Not able to choose who provides services	1.7	Choice
Transport	1.6	Services
Staff badge/role not displayed	1.4	Staff
Any other concerns about the respite facility	1.4	Environment
Cleanliness and maintenance of the respite facility	1.2	Environment
Feeling safe in the respite facility	0.9	Environment

Concern	% of all main concerns	Domain
Not included in planning/decision making	0.9	Choice
Being connected with the community	0.8	Services
Being treated like a child	0.8	Dignity
Medical (e.g. continence, wounds, pain)	0.8	Personal/medical
Any other concerns about personal or medical care	0.8	Personal/medical
Any other concerns about being treated with dignity and respect	0.6	Dignity
Showering, grooming or dressing	0.5	Services
Being shouted at by staff	0.5	Dignity
Needs and wishes not considered	0.5	Dignity
Mobility and falls prevention	0.5	Personal/medical
Independence not supported e.g. not able to leave the house	0.3	Choice
Not able to choose required services	0.3	Choice

4.7.1 Concerns related to funding issues

About a quarter (26.5%) of CHSP respite respondents' main concerns were thought to be related to funding issues, with the most common of those concerns being in the finances and service administration domain (Table 23). The free responses indicated that clients generally felt that having more hours would be helpful because out-of-budget costs were too high. These results share similarities with those observed for the HCP sample group. Though funding issues were defined and explained to respondents as being reflective of inadequate Government funding allocated to the client however notes taken by interviewers suggest that some respondents did not distinguish between funding allocated to their own services and funding to the sector overall.

Table 23: Main concerns related to funding for CHSP respite clients

Domain	% of all funding-related concerns
Finances & administration	41.8
Staff	18.1
Services	15.0
Choice	12.8
Dignity & respect	5.3
Respite environment	3.4
Personal & medical care	1.8
Respite facility	1.8

Unlike in the HCP sample, funding-related concerns for CHSP respite clients were significantly more prevalent in major cities (33.5%) compared to inner regional (11.6%) and outer regional/remote/very remote areas (11.9%; $p < 0.001$). However, the proportion of concerns believed to be due to funding issues was not significantly different between the provider types ($p = 0.37$).

No difference was observed when considering whether the interview was completed by the client or their proxy. Women were more likely than men to indicate having funding-related concerns (29.4% of women's concerns vs 19.9% of men's concerns; $p = 0.009$). Different proportions of concerns thought to be due to

funding issues were observed between age groups, with an increasing pattern from ages 55-84 (18.8-32.0%), dropping between ages 85-94 (19.3%) and increasing again from age 95 (34.8%).

4.7.2 COVID-19 related concerns

Similar to the HCP sample, 11.7% of CHSP respite clients' main concerns were identified as being related to the COVID-19 pandemic. The most common areas in which concerns were due to COVID-19 were in services and choice (Table 24), with the most frequently cited individual concern item being loneliness and boredom (12.5% of all COVID-related concerns). Respondent comments indicated some concerns about staff cleaning practices and hand hygiene, inability to get out and about, and unavailability of staff due to staff/providers limiting close contact with others.

Table 24: Concerns related to COVID-19 for CHSP respite clients

Domain	% of concerns due to COVID-19
Services	32.2
Choice	23.0
Finances & administration	21.0
Staff	20.1
Respite facility	3.8

4.8 Reporting of concerns

4.8.1 Complaints

In the CHSP respite sample over half (58.2%) of main concerns were discussed with others (i.e. became complaints). See Figure 17 for a flow diagram of the key results of this part of the questionnaire and Table 51 in the Appendix for further details about which main concerns became complaints, how they were reported and if they were resolved. Only concerns representing a proportion greater than 5.0% of the relevant category are listed below.

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

1. Value for money (e.g. fees too high) (9.7%)
2. Any other concerns about finances and administration (7.5%)
3. Transparency around fees & charges (6.5%)
4. Lack of clarity about what I am entitled to (5.7%)
5. Continuity of staff (5.4%)
6. Any other concerns about services (5.4%)

The likelihood of discussing concerns did not differ between clients and proxies. Reporting of complaints was significantly more likely in major cities (78.0%) compared to inner regional areas (49.4%) and outer regional (40.3%) areas ($p < 0.001$).

4.8.2 Unreported concerns

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

1. Lack of clarity about what client is entitled to (10.2%)
2. Value for money (e.g. fees too high) (8.4%)
3. Transparency around fees & charges (8.2%)
4. Staff not being adequately trained (8.0%)
5. Loneliness and boredom (6.5%)

See Table 51 in the Appendix for an expanded list. Respondents were able to give multiple reasons why each main concern was not reported. The main reason CHSP respite clients did not share their concerns with others was that they 'were only receiving the service for a short time and it was not worth complaining' (72.3%). The next most common reason was that clients did 'not have the capacity to complain' (18.5%). There were also small numbers who did not want to be a nuisance or make a fuss (8.9%), were not sure who to complain to or were not sure how, or did not think anything would change.

Of the main concerns unreported because clients thought the short duration of service made it not worth complaining, the most frequent (as a share of all such concerns) were:

1. Value for money (e.g. fees too high) (10.7%)
2. Transparency around fees and charges (8.3%)
3. Inadequate correspondence or information (6.5%)
4. Staff not being adequately trained (6.4%)
5. Meal preparation (5.8%)
6. Any other concerns about finances and administration (5.0%)

The main concerns most commonly not discussed with others because the client did not have the capacity to complain (as a share of all such concerns) were:

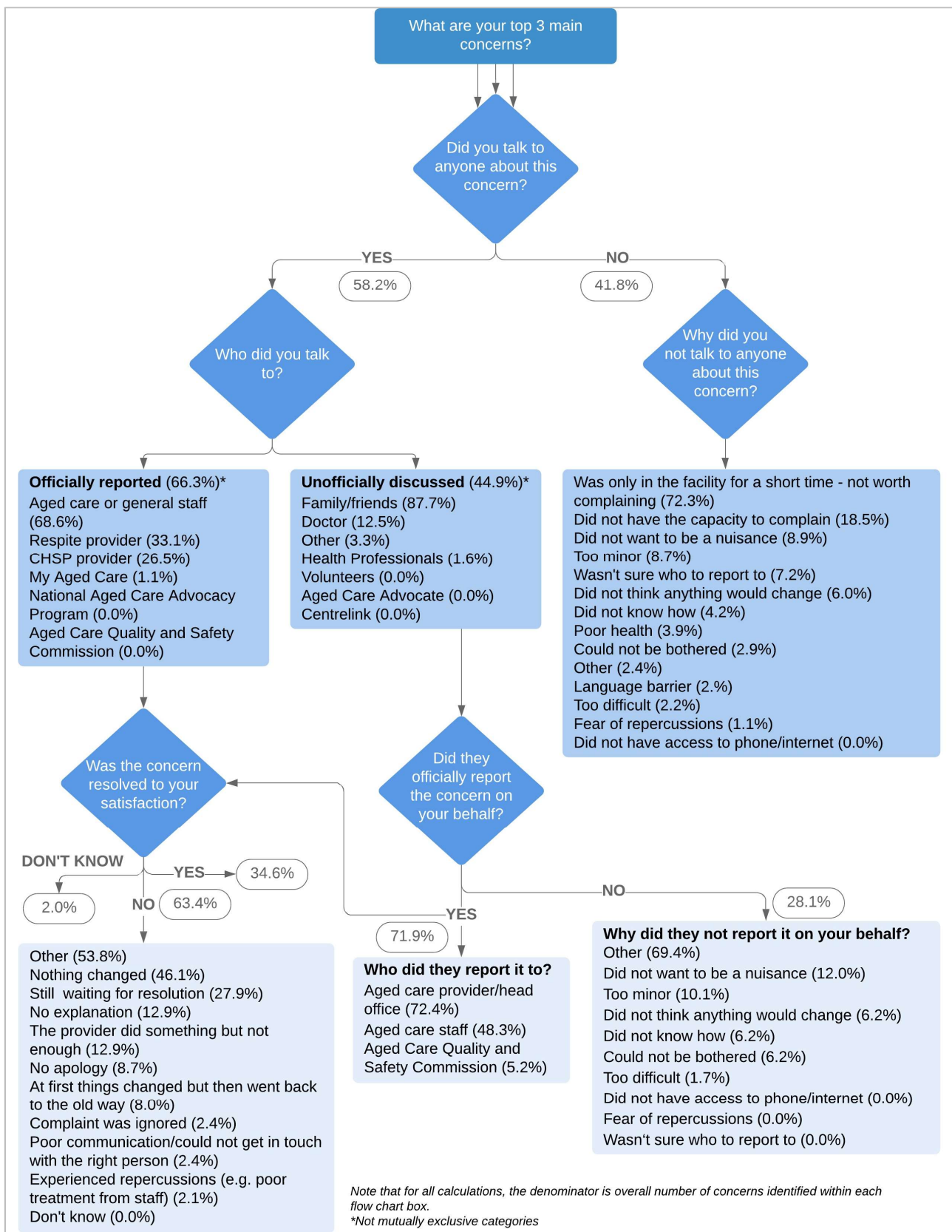
1. Staff not being adequately trained (19.4%)
2. Inadequate correspondence or information (12.3%)
3. Continuity of staff (11.5%)
4. Lack of clarity about what I am entitled to (7.1%)
5. Loneliness and boredom (7.1%)
6. Transparency around fees and charges (6.1%)
7. Any other concerns about finances and administration (6.1%)
8. Staff not on time/cancel regularly (5.8%)
9. Staff badge/role not displayed (5.7%)

The main concerns most commonly not discussed with others because the client did not want to be a nuisance or make a fuss (as a share of all such concerns) were:

1. Staff not being adequately trained (12.7%)
2. Loneliness and boredom (12.7%)
3. Staff not on time/cancel regularly (12.7%)
4. Poor communication between staff (12.7%)
5. Services not tailored to my needs (12.7%)
6. Not included in planning/decision making (12.7%)
7. Continuity of staff (11.8%)
8. Not able to choose when and how services are provided (11.8%)

See Table 52 in the Appendix for expanded lists of the above.

Figure 17: Flow chart of responses regarding reporting and resolution of concerns for CHSP respite clients



4.8.3 Recipients of complaints

For each main concern, a complaint could be made to multiple recipients. Official reporting (that is, reporting beyond family or friends) occurred for 66.3% of complaints, while 44.9% were shared unofficially. Official complaints alone were more likely to be made when the interview was completed by clients themselves than by proxies (84.3% vs 61.6%, $p<0.001$). Official reporting did not differ across provider type.

Of all complaints, 46.6% were to aged care or other staff, and 22.4% and 18.0% were to the CHSP or respite provider, respectively. No complaints were reported to the ACQSC or ACAT and only a minor proportion were reported to My Aged Care (0.8%). Nearly half of the concerns were shared with people in unofficial capacities such as family/friends (43.2% of all official or unofficial complaints, or 87.7% of concerns shared unofficially; see Figure 17). The similar shares of complaints to aged care staff and friends/family are unlike in HCP and residential respite, where it was most likely that concerns were discussed with staff.

4.8.4 Complaints on behalf of clients

The majority (71.9%) of concerns that clients did not officially report themselves were then reported on their behalf by family/friends. No other recipient of unofficial complaints reported them on clients' behalf. Of the concerns that were passed on by clients' family/friends, most (56.0%) were reported directly to head office and almost all the remainder reported to staff (32.7%). No concerns were reported to the ACQSC on behalf of CHSP respite clients.

The most common reason that concerns were not reported by family/friends was 'other' (68.9% of concerns not reported on clients' behalf by family/friends). Free responses generally indicated that nothing could be done about those concerns due to COVID-19 or lack of confidence that anything would – or could – be done. Some respondents suggested that needs relating to clients' conditions, such as dementia, were either poorly understood by staff or were barriers to resolution. One proxy respondent did indicate that the concern was not passed on because the client 'is a chronic whinger'. While not a common response on this survey, it does raise the possibility that some elderly people have concerns that are important to them but are dismissed by others upon whom they rely for support, and may therefore be denied opportunities for resolution of those concerns.

The next most common reason was that they did not want to be a nuisance (12.0% of concerns not reported on clients' behalf by anyone); however, when restricted only to family and friends, the next most common reason for not passing complaints on was that they believed the concern to be too minor (24.9% of concerns not reported on clients' behalf by family/friends).

4.9 Resolution of official complaints

Of the main concerns that were officially reported, nearly two-thirds (63.4%) were not resolved to the CHSP respite client's satisfaction. Complaints were more likely to be seen as resolved satisfactorily when the survey was completed by a proxy (41.3%) than by the client themselves (21.0%; $p<0.001$). It is possible that having the survey completed by a proxy indicates clients have more support and advocacy from their representatives to ensure that concerns are resolved; however, that was not specifically investigated in this survey.

Complaints were more likely to have been resolved for clients living in major cities compared to those in inner regional or outer regional/remote/very remote areas ($p<0.001$). They were also more likely to be resolved for clients with for-profit providers (75.0%) than with government (48.9%) or non-profit (29.4%) providers ($p<0.001$).

The primary reasons why official complaints were unresolved was that nothing had changed (46.1%), which was the case across all the official complaint recipients. In 27.9% of cases, the client was still waiting for a resolution, or the provider had taken some action but not enough (12.9%), or things had changed and then

gone back to the old way (8%). Repercussions such as poor treatment from staff had been experienced in 2.1% of cases.

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

1. Value for money (e.g. fees too high) (8.7%)
2. Transparency around fees and charges (8.6%)
3. Continuity of staff (7.9%)
4. Any other concerns about being given enough choice (7.0%)
5. Any other concerns about finances and administration (6.3%)
6. Any other concerns about services (6.2%)
7. Staff attitude, body language or conduct, like staff being unkind, rude, or unhappy (5.9%)

See Table 56 in the Appendix for an expanded list.

A greater proportion of complaints were resolved satisfactorily when they were reported directly to staff (either by the client or by someone on their behalf; 47.8%). In comparison, 25.3% of complaints that were reported to the provider head office were resolved.

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

1. Value for money (e.g. fees too high) (14.4%)
2. Staff being mismatched to my preferences (e.g. not preferred gender) (13.0%)
3. Any other concerns about finances and administration (11.4%)
4. Lack of clarity about what I am entitled to (11.0%)
5. Any other concerns about services (7.0%)
6. Loneliness and boredom (7.0%)
7. Inadequate correspondence or information (6.7%)
8. Continence pads (e.g. forced use, insufficient supply or changing) (6.7%)
9. Staff not being adequately trained (6.0%)

See Table 56 in the Appendix for an expanded list. When grouping complaints into domains, official complaints with the highest rate of satisfactory resolution were those relating to staff (44.6%), followed by those about services (43.9%) and dignity and respect (40.0%). The two domains of complaints that were most likely to be discussed with others (unofficially or officially) were also those least likely to be resolved to clients' satisfaction (Table 25). All main concerns relating to personal and medical care (which account for only 1.7% of all main concerns) were shared with others, and more than half were then officially reported by the client or on their behalf; however, none of these complaints were satisfactorily resolved. A high proportion (78.6%) of concerns about the respite environment were discussed with others, and all of those instances included officially reporting complaints; however, none of those complaints were resolved.

Table 25: Sharing, reporting and resolution of concerns by domain – CHSP respite clients

Domain of concern	% shared with anyone	% of concerns in each domain that were officially reported		% of concerns in each domain officially reported that were resolved
		By client	On behalf of client*	
Personal & medical care	100	50.0	66.7	0.0
Respite environment	78.6	78.6	N/A	0.0
Dignity and respect	72.4	51.7	100	40.0
Finances & administration	60.7	44.6	84.4	39.1
Services	57.4	36.1	42.3	43.9
Staff	55.4	34.3	92.1	44.6
Choice	52.0	31.2	60.7	25.6
Medical & health care	40.0	0.0	0.0	N/A
Respite facility	33.3	33.3	N/A	0.0

* That client did not officially report themselves

5 Residential respite results

5.1 Recruitment

A total of 203 interviews were completed with the residential respite group (Table 26). A majority (60.1%) were completed by proxies and one (0.5%) required an interpreter. Three of the proxy interviews were completed on behalf of clients who were in residential respite at the time of the interview.

Table 26: Number of residential respite interviews by remoteness

Location	n
Major Cities of Australia	
Non-Profit	58
For-Profit	46
Government	1
Unknown provider type	17
Inner Regional Australia	
Non-Profit	30
For-Profit	9
Government	9
Unknown provider type	2
Outer Regional/Remote/Very Remote	
Non-Profit	13
For-Profit	9
Government	3
Unknown provider type	6
Total n	203

5.2 Demographics

A majority of the residential respite group were female (unweighted percentages of 57.1% vs 42.9% males) (Table 27). The majority of participants (76.8%) were between the ages of 75 and 94 years.

Table 27: Demographic characteristics of residential respite respondents, total n=203

Characteristic	n (unweighted)	Unweighted %	Weighted %
Sex	Female	116	57.1%
	Male	87	42.9%
Age (years)	55-64	1	0.5%
	65-74	32	15.8%
	75-84	65	32.0%
	85-94	91	44.8%
	95+	14	6.9%
			6.7%

5.3 Quality of care

In general, the results from the Quality of Care questionnaire indicate around half or more of the residential respite clients were only partially satisfied with the care they received and a significant minority were highly unsatisfied.

The majority of residential respite clients reported that they were 'always' treated with respect and dignity (72.3%) and 18.2% felt they were 'mostly' treated this way. In the other domains, between 40-60% of residential respite clients were 'always' satisfied and roughly 21-27% were 'mostly' satisfied except in the complaints related domains. For example, nearly one-third (30.4%) of residential respite respondents 'never' knew how to lodge a complaint, and 18.1% 'never' felt comfortable in lodging a complaint. In addition, 29.5% of respondents felt that they were only sometimes (or less often) confident that appropriate action would be taken when they made a complaint (Figure 18 and Appendix Table 53).

In addition to the low results for the complaints questions, a significant minority felt that quality of care was lacking in other domains. Of all residential respite respondents, 25.0% said they 'never', 'rarely' or 'sometimes' received the support to make their own decisions about the care and services they receive, 12.7% said they only sometimes (or less often) received care from aged care staff who have the appropriate skills and training, and 27.3% said they only sometimes (or less often) were supported to maintain their social relationships and connections with the community.

When grouping responses by individual clients, 26.9% were 'always' satisfied in all areas, 27.4% were at least 'mostly' satisfied in all areas (not including 'always') and 45.7% were 'sometimes' or less often satisfied in an area (Figure 19).

5.4 Life satisfaction and quality

5.4.1 General life satisfaction

GLS scores ranged from 0.0-10.0 (where 10 is the highest GLS). The mean GLS for all residential respite clients at the time of the interviews was 6.8 (SD 2.3) with a median of 7.0 (IQR 5.0-8.0). When asked to rate their satisfaction with life before the COVID-19 pandemic, the mean GLS was 7.2 (SD 2.2) and the median was 8.0 (IQR 6.0-9.0). The decline from before the COVID-19 pandemic to the time of the interview was significant ($p<0.001$). There were no significant differences in GLS scores across provider type or remoteness areas.

5.4.2 General quality of life

Total CASP-12 scores for residential respite clients ranged from 19.0 to 46.0 (where 48.0 is the highest self-reported quality of life), with a mean of 33.7 (SD 5.8) and a median of 33.0 (IQR 30.0-38.0). Proxies reported significantly lower CASP-12 scores (mean 32.4, SD 5.7) than the clients themselves reported (mean 35.2, SD 5.5; $p<0.001$). There were no significant differences across provider types or remoteness areas.

The results for individual responses within the CASP-12 are shown in Table 54. A significant proportion of residents feel constrained by their age, a loss of control, unable to do what they want, or lack a sense of meaning, lack energy, don't feel that life is full of opportunities, and don't think the future looks good. It could not be determined if this relates to poor and/or declining health, as personal information on health status was not collected.

5.4.3 Social care-related quality of life

SCRQoL scores on the ASCOT SCT-4 for all residential respite clients ranged from 0.1 to 1.0 (where a score of 1.0 indicates the highest SCRQoL). Mean SCRQoL for all residential respite clients was 0.8 (SD 0.2) with a median of 0.8 (IQR 0.7-0.9). Proxies reported significantly lower SCRQoL scores (median 0.7, IQR 0.6-0.9) than clients themselves reported (median 0.8, IQR 0.8-1.0; $p<0.001$). There were no differences across provider type or remoteness areas.

The individual responses to the ASCOT SCT-4 for residential respite clients are shown in Table 55 in the Appendix. Even though the results overall were quite positive, a proportion felt they had less than adequate control over daily life (38.0%), social contact (28.5%), or occupation (38.5%).

Figure 18: Quality of Care – residential respite clients: percentage by response category

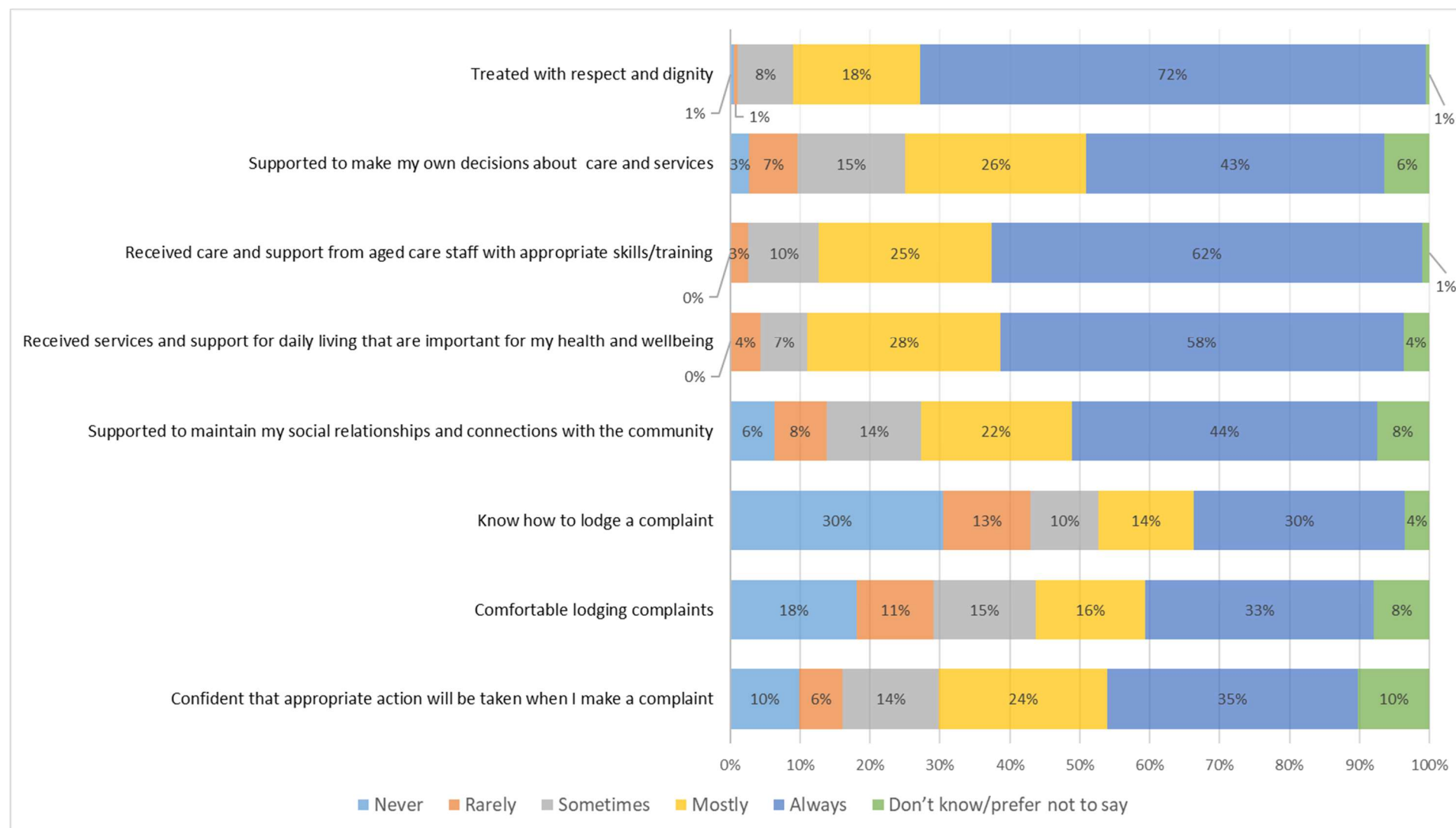
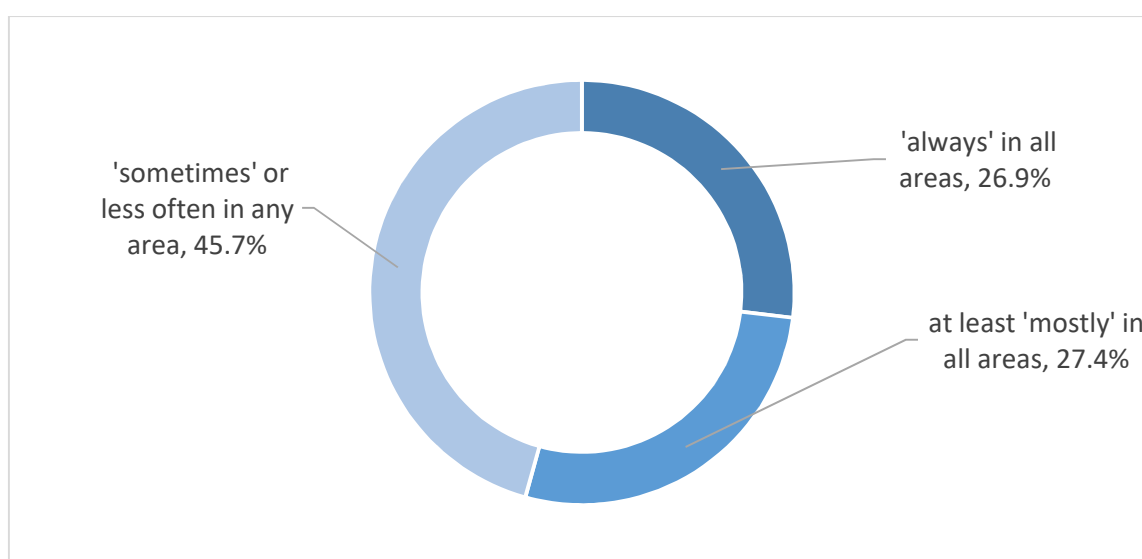


Figure 19: Quality of Care – residential respite clients: percentage across areas



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

5.5 Relief for carers

When proxies were asked about how helpful residential respite services were in providing relief for them as a carer, most (88.8%) indicated that the services helped 'a great deal', or were 'much' help (Table 28). Only 3.7% found residential respite services to be of little or no help.

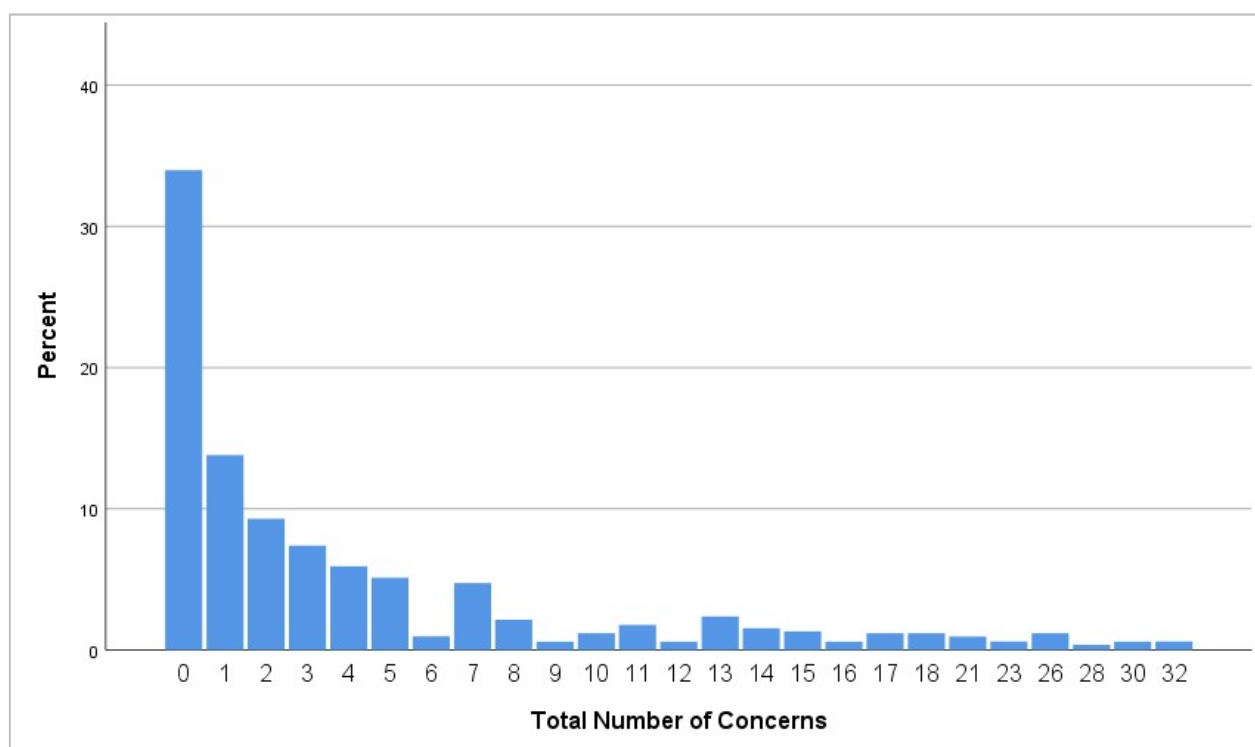
Table 28: Degree to which respite services helped in relieving the carer

Degree to which respite services relieved carer	CHSP respite (%)	Residential respite (%)
Not at all	0.0	0.5
Little	5.0	3.2
Somewhat	14.7	7.5
Much	17.5	19.3
A great deal	61.0	69.5
Don't know	0.9	0.0
Prefer not to say	0.9	0.0

5.6 Concerns

The number of concerns identified by residential respite respondents ranged from 0 to 32 (from a possible 64) (Figure 20). The mean number of total concerns was 4.4 (SD 6.4) and the median was 2.0 (IQR 0.0-5.0).

Figure 20: Number of concerns per residential respite respondents



There was a fairly even spread of prevalence of concerns across all domains (Table 29). Concerns were most commonly related to the fees and services domain (38.5%), which included feeling lonely or bored (16.9%), the food and dining experience (16.4%) and lack of interesting activities for clients (10.0%). Concerns about staff (31.0%) included understaffing (18.7%), call bells not being answered (16.0%), and inadequate training (10.5%). Concerns in the medical and health care domain (29.3%) were particularly about medication management (17.8%) and the quality and access to allied health services. Over a quarter of clients (26.3%) had concerns about not being treated with dignity and respect, which included the client not being allowed to do certain things, their needs and wishes not being considered, and being treated like a child. The 95% confidence intervals around those proportions were moderate in overall size, averaging 4.4%.

There was no significant difference in the number of concerns identified when the interview was completed by the client or by their proxy ($p=0.65$).

No significant difference was observed in the number of concerns between the different provider types ($p=0.37$). The median number of concerns was 1.0 (IQR 0.0-5.0) in for-profit, 2.0 (IQR 0.0-6.1) in non-profit, and 1.0 (IQR 0.0-3.0) in government-run organisations. There was also no significant difference observed in number of concerns between people living in the different remoteness areas ($p=0.21$). The median number of concerns was 2.0 (IQR 0.0-6.5) in outer regional/remote/very remote, 2.0 (IQR 0.0-7.0) in major cities and 1.0 (IQR 0.0-3.0) in inner regional areas.

Table 29: Concerns of residential respite respondents

Domain	% with a concern in this domain (95% CI)	Concerns within domain	% of total RR sample	95% CI	
				Lower	Upper
Services and fees	38.5 (34.3-42.9)	Feeling lonely or bored	16.9	13.7	20.4
		Food, catering and dining experience	16.4	13.4	20.0
		Having interesting lifestyle activities	10.0	7.6	13.0
		Quality of laundry services	8.8	6.5	11.7
		Fees and charges	8.2	6.0	11.0
		Social engagement with the community	7.3	5.2	9.9
		Access and reliability of internet/WIFI	5.1	3.4	7.4
		Other	3.3	2.0	5.3
Staff	31.0 (27.0-35.3)	Understaffed or not enough staff on duty	18.7	15.4	22.3
		Call bell not being answered	16.0	13.0	19.6
		Concerns about communication between staff, such as poor handover between shifts	12.2	9.5	15.3
		Staff not being adequately trained	10.5	7.9	13.4
		Agency staff do not know me and my needs	9.3	6.9	12.1
		Other	5.8	4.0	8.3
		Staff being mismatched to client's preferences	5.7	3.8	8.1
		Staff body language or attitude, like staff being unkind, rude, or unhappy	5.5	3.7	7.9
		Staff name badge/role not being displayed	4.8	3.0	6.9
		Staff culture or facility culture	3.3	2.0	5.3
		Being hurt or treated roughly by staff	3.0	1.7	4.8
		Staff not being culturally sensitive	2.4	1.2	4.1
		Use of restraint	0.6	0.1	1.7
Medical and health care	29.3 (25.5-33.6)	The way your medication is managed	17.8	14.6	21.5
		Accessing allied health services (e.g. physio, podiatry etc.)	7.8	5.7	10.5
		Quality of allied health services (e.g. physio, podiatry etc.)	5.1	3.4	7.4
		How pain is managed	4.9	3.2	7.2
		Falls or fall prevention	4.8	3.0	6.9
		How any wounds have been looked after	4.5	2.9	6.7
		Other	4.1	2.6	6.2
		Seeing a GP when needed	3.5	2.1	5.5
		How catheters are used	0.6	0.1	1.7
Choice	27.9 (24.0-32.0)	Having enough lifestyle activities to choose from	10.8	8.2	13.8
		Other	9.0	6.7	11.9
		Choices about personal care, like choosing when to shower	8.1	5.8	10.8

Domain	% with a concern in this domain (95% CI)	Concerns within domain	% of total RR sample	95% CI	
				Lower	Upper
		Choices about how and when you interact with other residents	6.3	4.3	8.8
		Not being allowed out of bed/chair/room, or not being allowed outside	5.7	3.8	8.1
		Choices around the timing of meals	4.2	2.7	6.5
		Choices about how and when you receive visitors	3.3	2.0	5.3
Dignity and respect	26.3 (22.5-30.4)	Not being allowed to do certain things	12.1	9.5	15.3
		Needs and wishes not considered	11.9	9.3	15.1
		Being treated like a child	10.9	8.4	14.0
		Not being informed of daily routine	9.9	7.4	12.7
		No individualised care plan	6.8	4.8	9.4
		Continence pads (e.g. forced use, insufficient supply or changing)	3.9	2.4	6.0
		Other	3.6	2.1	5.5
		Being shouted at by staff	1.9	0.8	3.3
Room	25.1 (21.4-29.2)	Noise	11.8	9.1	14.9
		Other	7.9	5.7	10.5
		The privacy of your room	6.7	4.7	9.2
		Cleanliness and maintenance of your room and bathroom	6.2	4.3	8.8
		The security of your room and possessions	5.2	3.5	7.6
		Feeling safe in your room	4.6	3.0	6.9
Facility	18.9 (15.6-22.5)	Other	8.7	6.4	11.4
		Noise levels in the facility	8.4	6.2	11.2
		The cleaning and maintenance of equipment, furniture and gardens	5.5	3.7	7.9
		Safety of the facility	4.2	2.6	6.2
		The overall appearance of the facility	2.7	1.5	4.6
Personal care	18.2 (15.0-21.9)	How you are helped to shower	6.1	4.2	8.5
		How you are helped to get around	4.9	3.2	7.2
		How you are helped with continence aids	4.5	2.9	6.7
		How you are helped with eating	4.3	2.7	6.5
		How you are helped with personal grooming, like cutting nails or shaving	4.3	2.7	6.5
		Other	3.7	2.3	5.8
		How you are helped to use to the toilet	3.6	2.1	5.5

5.6.1 Correlation with life satisfaction and quality

Residential respite clients who identified greater numbers of concerns had lower life satisfaction and quality of life on all measures. There were significant negative correlations between total number of concerns and GLS ($r=-0.28$, $p<0.001$), CASP-12 ($r=-0.31$, $p<0.001$) and SCRQoL scores ($r=-0.40$, $p<0.001$).

5.7 Main concerns

Most residential respite clients (66.0%) reported at least one main concern and nearly half (40.8%) identified the maximum of three concerns. Around one third (34.0%) reported no main concerns. The mean number of main concerns was 1.6 (SD=1.3) and the median was 2.0 (IQR 0.0-3.0).

Table 30 shows the most common main concerns related to medication management, understaffing, meals, and feeling lonely or bored.

Table 30: Main concerns – residential respite

Concern	% of all main concerns	Domain
The way medication is managed	8.2	Medical/health
Food, catering & dining experience	5.8	Services/fees
Feeling lonely or bored	5.2	Services/fees
Understaffed or not enough staff on duty	4.8	Staff
Any other concerns about choice	4.3	Choice
Call bell not being answered	3.6	Staff
Any other concerns about being treated with dignity and respect	3.6	Dignity & respect
Noise	3.6	Room
Having enough lifestyle activities to choose from	3.4	Services/fees
Any other concerns about the facility	3.2	Facility
Accessing allied health services (e.g. physio, podiatry etc.)	3.1	Medical/health
Cleanliness and maintenance of client's room and bathroom	2.7	Room
Being treated like a child	2.6	Dignity & respect
Any other concerns about the room	2.5	Room
Quality of laundry services	2.3	Services/fees
Staff not being adequately trained	2.3	Staff
Concerns about communication between staff, such as poor handover between shifts	2.2	Staff
Having interesting lifestyle activities	2.1	Services/fees
Any other concerns about staff	1.7	Staff
Choices about how and when to interact with other residents	1.7	Choice
Any other concerns about medical and health care	1.6	Medical/health
Noise levels in the facility	1.5	Facility
Social engagement with the community	1.5	Services/fees
Choices about personal care, like choosing when to shower	1.5	Personal care
How client was helped with continence aids	1.5	Personal care
Fees and charges (increasing or many additional costs/everything is an extra cost or confusing)	1.5	Services/fees
Staff being mismatched to client's preferences (e.g. not preferred gender)	1.4	Staff
Any other concerns about personal care	1.4	Personal care
How client was helped with personal grooming	1.3	Personal care
Any other concerns about services and fees	1.1	Services/fees
Not being informed of daily routine	1.1	Dignity & respect
Falls or fall prevention	1.1	Medical/health

Concern	% of all main concerns	Domain
Staff name badge/role not being displayed	1.1	Staff
Agency staff do not know client and their needs	1.1	Staff
Privacy of the room	1.1	Room
Seeing a GP when needed	1.0	Medical/health
How pain is managed	1.0	Medical/health
Access and reliability of internet/WIFI	1.0	Services/fees
The overall appearance of the facility	0.8	Facility
Continence pads (e.g. forced use, insufficient supply or changing)	0.7	Dignity & respect
Choices around the timing of meals	0.7	Choice
Not being allowed to do certain things	0.6	Dignity & respect
How any wounds have been looked after	0.6	Medical/health
The security of client's room and possessions	0.6	Room
How client was helped with eating	0.4	Personal care
Being shouted at by staff	0.4	Dignity & respect
How client was helped to shower	0.4	Personal care
How client was helped to use to the toilet	0.4	Personal care
How client was helped to get around	0.4	Personal care
How catheters are used	0.4	Medical/health
Safety of the facility	0.4	Facility
Staff attitude, body language or conduct, like staff being unkind, rude, or unhappy	0.4	Staff
Staff culture or facility culture	0.4	Staff
Staff not being culturally sensitive	0.4	Staff
Feeling safe in client's room	0.4	Room

5.7.1 Concerns related to funding issues

Of all the concerns that residential respite respondents said were most important to them, 20% were thought to be related to funding issues. The majority of these concerns had to do with the services received, followed by staff (Table 31). The individual concern which clients most frequently thought was funding related was understaffing at residential aged care facilities (15.3% of all funding-related concerns), which suggests that respondents did not distinguish between funding allocated to their own services and funding to the sector overall, even though funding issues were defined and explained to respondents as being reflective of inadequate Government funding allocated to the client. Interviewer notes indicated that also a frequent concern was having to share rooms or toilet facilities while in residential respite, or having to book a place far in advance due to limited available spaces.

There was no significant difference in the proportion of concerns thought to be due to funding between remoteness regions ($p=0.54$), although there did appear to be a trend toward major cities having more funding-related concerns (21.2%), followed by inner regional areas (19.6%) and with the smallest proportion of funding-related concerns in outer regional areas (16.7%). The proportion of concerns thought to be due to funding was not different by the provider organisation type for residential aged care facilities at which clients received their respite ($p=0.44$).

Table 31: Main concerns related to funding for residential respite clients

Domain	% of all funding-related concerns
Services	35.7
Staff	28.0
Medical & health care	10.5
Personal care	8.0
Respite facility	4.8
Choice	4.1
Dignity & respect	3.2
Respite environment	3.2
Respite room	2.6

Client representatives were more likely to report concerns as being due to funding than clients themselves (25.2% vs 13.7%, $p<0.001$). Women were more likely than men to indicate having funding-related concerns (23.0% compared to 17.1%; $p=0.02$). Different proportions were observed between age groups, forming an 'inverted U' pattern across the age ranges. Clients in the lowest and highest age ranges were least likely to have funding-related concerns (0.0% of those aged 55-64 and 5.7% of those aged 95+), while clients aged 65-84 were most likely to have concerns due to funding issues (23.1-28.8%) and clients aged 85-94 were in the middle (14.6%).

5.7.2 COVID-19 related concerns

A smaller proportion of the residential respite client sample indicated that their concerns were related to the COVID-19 pandemic (3.5%) compared to the HCP and CHSP respite groups. This is likely because clients completing the survey may have had their residential respite experiences prior to the COVID-19 pandemic. The sample list from which clients were recruited indicated they had received respite services in the period between November 2019 and January 2020. Additionally, many people may either have chosen not to enter into residential respite during the pandemic, or were not able to do so due to residential aged care facilities' restrictions.

The most common areas in which concerns were due to COVID-19 were staff and medical care (Table 32). Respondents most frequently indicated that residential aged care facilities were understaffed and that staff were unable to cope with the additional demands required due to enforcing COVID-19 restrictions (18.9% of all COVID-related concerns). Clients felt lonely or bored because they could not have visitors, and some services were not available if certain staff members were away due to COVID-19. Multiple clients noted that they had difficulties seeing a GP or getting adequate treatment management information because doctors were unable to enter the facilities.

Table 32: Concerns related to COVID-19 for residential respite clients

Domain	% of concerns due to COVID-19
Staff	28.4
Medical & health care	28.4
Services	24.4
Personal care	9.5
Dignity & respect	9.3

5.8 Reporting of concerns

5.8.1 Complaints

Nearly two-thirds (60.5%) of the main concerns raised by residential respite respondents were reported or discussed with others (i.e. became complaints), regardless of whether this was through official channels or unofficially (for example, with family or friends). Figure 21 gives a flow diagram of the key results in this part of the questionnaire, and Table 56 in the Appendix has further details about which main concerns became complaints, how they were reported and if they were resolved.

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

1. The way medication is managed (11.4%)
2. Food, catering and dining experience (7.3%)
3. Feeling lonely or bored (5.9%)
4. Any other concerns about being treated with dignity and respect (5.5%)

See Table 56 in the Appendix for an expanded list. Concerns were more likely to have been discussed with others, officially or unofficially, when the interviews were completed by proxy than when they were completed by clients (64.9% vs 51.0%; $p < 0.001$).

5.8.2 Unreported concerns

The top main concerns that were not discussed with others or reported (as a share of all unreported main concerns) were:

1. Understaffed or not enough staff on duty (5.8%)
2. Concerns about communication between staff, such as poor handover between shifts (5.6%)
3. Noise (5.2%)

A full list is available in Appendix Table 56. Respondents were able to give multiple reasons why each main concern was not discussed with anyone else. Similar to CHSP respite clients, the main reason residential respite clients did not share their concern with others was that they 'were only in the facility for a short time and it was not worth complaining' (69.7%). The next most common reasons were that clients did not have the capacity to complain (24.6%), or did not want to be a nuisance/make a fuss (22.1%), or thought the concern was too minor (17.2%). There were also small numbers who were not sure who to complain to or were not sure how, or did not think anything would change.

Of the main concerns not reported because the client was only in the facility for a short term and it was not worth complaining, the most frequent (as a share of all such concerns) were:

1. Understaffed or not enough staff on duty (6.4%)
2. Any other concerns about the facility (5.5%)
3. Being treated like a child (5.5%)
4. Noise (5.5%)
5. Choices about how and when to interact with other residents (5.0%)
6. Any other concerns about my room (5.0%)

Main concerns not reported because the client did not have the capacity to complain were most commonly (as a share of all such concerns):

1. Choices about how and when to interact with other residents (10.5%)
2. Having enough lifestyle activities to choose from (8.1%)
3. Concerns about communication between staff, such as poor handover between shifts (8.0%)
4. How I am helped with continence aids (8.0%)

5. Accessing allied health services (e.g. physio, podiatry etc.) (6.5%)

The main concerns unreported because the respondents did not want to be a nuisance or make a fuss tended to be (as a share of all such concerns):

1. Food, catering and dining experience (11.9%)
2. Having enough lifestyle activities to choose from (7.9%)
3. Having interesting lifestyle activities (7.9%)
4. Feeling lonely or bored (7.9%)
5. Any other concerns about choice (7.9%)
6. How I am helped with personal grooming, like cutting nails or shaving (7.9%)
7. Noise (7.9%)
8. Accessing allied health services (e.g. physio, podiatry etc.) (6.4%)
9. Cleanliness and maintenance of my room and bathroom (6.4%)

See Table 57 in the Appendix for expanded lists; only those concerns with proportions greater than 5.0% are listed above.

5.8.3 Recipients of complaints

For each main 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 occurred for 64.1% of the complaints, while 51.1% were shared unofficially (17.0% of complaints were shared both officially and unofficially). A higher proportion of complaints were said to have been made officially when clients' representatives completed the interview, compared to clients who completed the interview themselves (67.3% vs 53.3%; $p < 0.001$). Official reporting did not differ across provider type, but did vary across the different remoteness regions. For the residential respite sample, concerns were more likely to be officially reported for those in major cities (42.7%) compared to those in inner regional (32.1%) and outer regional (29.1%) areas ($p = 0.004$).

Of all complaints, the majority (63.8%) were discussed with aged care or other staff. Complaints were only infrequently reported to the respite or CHSP provider (8.4% and 2.0%, respectively). No complaints were reported to the ACQSC, My Aged Care or the National Aged Care Advocacy Program. Nearly half of the concerns were shared with people in unofficial capacities such as family/friends (47.1% of all official or unofficial complaints, or 92.9% of concerns shared unofficially). Figure 21 indicates the proportions of complaints as a share of whether they were reported officially or unofficially.

5.8.4 Complaints on behalf of clients

Most (59%) of concerns that clients did not report officially were then reported on their behalf by others. The majority of this third party reporting was done by family/friends, who reported 61.6% of the concerns that were discussed with them. Doctors reported concerns 8.5% of the time, and health professional reported concerns 0.0% of the time. Clients often did not know why complaints were not reported on their behalf by doctors or health professionals.

The majority of complaints reported on clients' behalf went directly to staff (95.1%) with a relatively small proportion going to head office (12.4%) and the ACQSC (3.0%). In a small number of cases, the respondents did not know to whom complaints had been reported on behalf of the clients (2.5%).

The most common reason that concerns were not reported on behalf of clients was 'other' (64.2% of concerns not reported on clients' behalf). Free responses indicated a number of reasons why official complaints were not made on behalf of clients. The most common response was that family members did not know about these

concerns until after the client had finished their residential respite and they either felt it was too late to complain or intended to complain but it had just recently occurred. Some proxy respondents did not know why these complaints were not passed on. Less common responses were assuming that the staff were already aware, that the RACF was not ideal for the client or that RACF rules made resolution not possible.

The next most common reason was that they believed the concern to be too minor (23.4% of concerns not reported on clients' behalf).

5.9 Resolution of official complaints

Of the concerns that were officially reported, nearly two-thirds (62.6%) were not resolved to the residential respite client's satisfaction. There were no statistically significant differences in this result between the proxy and client interviews. There were also no differences in the satisfactory resolution rate across provider type or remoteness.

The primary reason cited for complaints being unresolved was that nothing changed (58.2%). 'Other' was also a common reason for residential respite respondents' complaints not being resolved (52.2%). The free responses associated with these indicated largely that systemic issues such as understaffing, underfunding to the sector, and providers 'not caring' were perceived as the main barriers to successful complaint resolution. In 9.0% of cases, the provider had taken action but not enough. Repercussions such as poor treatment from staff had been experienced in 3.0% of cases.

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

1. The way medication is managed (21.8%)
2. Any other concerns about being treated with dignity and respect (8.2%)
3. Quality of laundry services (7.2%)
4. Having enough lifestyle activities to choose from (5.4%)
5. Fees and charges (increasing or so many additional costs/everything is an extra cost or confusing) (5.4%)

When complaints were made to staff, 39.4% were resolved satisfactorily, and when made to the respite provider head office, 23.9% were resolved satisfactorily.

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

1. The privacy of my room (9.0%)
2. Staff not being culturally sensitive (caring about my beliefs, values, spirituality, customs or religion) (7.9%)
3. Seeing a GP when needed (7.1%)
4. Any other concerns about being treated with dignity and respect (7.0%)
5. Cleanliness and maintenance of my room and bathroom (5.9%)

See Table 56 in the Appendix for a full list. Complaints regarding clients' medical and health care, and their personal care, were the most likely to be resolved (58.7% and 45.5% of the time). In both of those domains, complaints that were not officially reported by clients were then reported on their behalf 100.0% of the time (Table 33). This may suggest that the support and advocacy of others could play a role in improving the likelihood of satisfactory resolution, that concerns relating to medical, health and personal care were more resolvable, or that they were a greater priority for staff and providers to rectify. When the complaints related to choice they were least likely to be resolved satisfactorily (28.0% of the time). Concerns regarding the respite environment, facility or room, and staff were also only resolved satisfactorily about one-third of the time (29.2-32.1%).

Figure 21: Flow chart of responses regarding reporting and resolution of concerns for residential respite clients

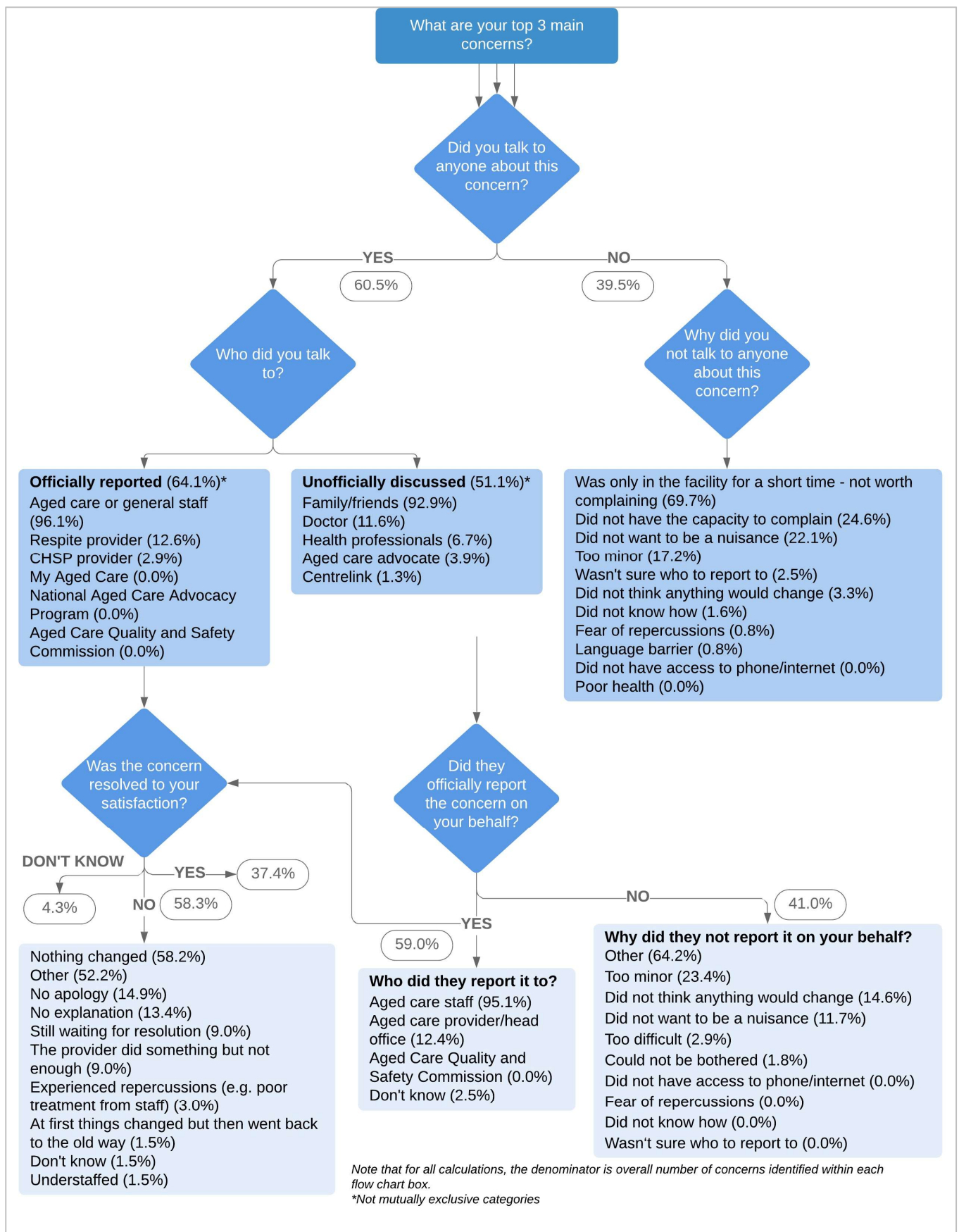


Table 33: Sharing, reporting and resolution of concerns by domain – residential respite clients

Domain of concern	% shared with anyone	% of concerns in each domain that were officially reported		% of concerns in each domain officially reported that were resolved
		By client	On behalf of client*	
Medical & health care	79.7	39.0	50.0	58.7
Respite room	67.7	61.9	100.0	31.6
Respite facility	64.3	60.7	0.0	30.4
Services	62.9	38.6	56.7	38.1
Dignity and respect	60.4	37.4	66.7	39.4
Personal care	55.6	41.5	100.0	45.5
Choice	49.4	37.8	100.0	28.0
Staff	48.9	28.8	60.9	32.1
Respite environment	47.5	40.7	50.0	29.2

* That client did not officially report themselves

6 Impact of COVID-19

At the end of the survey respondents were asked three open-ended questions to assess the impact of the COVID-19 pandemic on clients' circumstances and needs, and how this may have affected the services being delivered by providers. The results in this section include respondents from HCP, CHSP respite and residential respite and are unweighted.

When asked if their circumstances or needs have changed due to COVID-19, 60.3% of all respondents indicated they had. For these respondents, free-responses were subsequently coded into the themes. Almost one-quarter said they were feeling isolated from family and friends (24.0%) and that they had lost freedoms (20.4%) such as going outside or being able to continue their normal activities. About 3.8% of respondents felt that they had lost their independence due to COVID-19. A small share (3.5%) stated that the biggest impact COVID-19 had on them were feelings of anxiety around catching the virus and dying. An even smaller proportion (1.0%) reported feeling more at peace or happier as a result of being able to slow down since restrictions associated with the COVID-19 pandemic were implemented.

A large proportion (68.8%) of respondents said their use or opinion of the aged care services they receive had not changed due to COVID-19. Of those whose service usage changed, these decisions were made either by clients and their families or by providers in response to the pandemic. For example, 7.2% of the respondents said that their providers had restricted services due to COVID-19, while 4.0% stated that they had chosen to temporarily reduce or end their services out of fear of catching the virus. Some respondents (1.7%) highlighted that they were not able to access respite care services at all due to COVID-19. A smaller number (0.7%) said they felt their services providers were not prepared or adequately adhering to safety precautions, such as wearing appropriate personal protective equipment (PPE).

When asked how their service provider responded to COVID-19, 18.0% stated that there had been no changes. Many (37.8%) said that they were provided with information and offered extra support if needed. Other common responses indicated that respondents had been provided with extra support (7.4%) and that the care workers were adhering to safety precautions and using PPE correctly (11.0%). Around 10.0% of respondents stated that their service provider had responded well or very well to the challenges associated with COVID-19 and that they were happy with their services. On the other hand, some respondents stated that their providers had cancelled or reduced several of their services (3.6%), while others (2.7%) said that they had cancelled or reduced services themselves out of fear of getting COVID-19. Small shares of respondents reported that there had been no communication from their service providers at all (4.5%), and some (1.0%) said that their care workers refused to use PPE or were not adequately using it when they entered their homes.

The longer-term impacts of COVID-19 are unknown but are likely to be far-reaching, particularly as the pandemic continues and restrictions have been re-introduced in some places. Access to services may be further limited or not available at all, for example outbreaks in aged care facilities will impact availability of residential respite services. Government and industry need a comprehensive plan to understand and address any downstream issues for HCP, CHSP respite and residential respite clients.

7 Discussion and implications

7.1 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 questionnaire indicate that while HCP, CHSP respite and residential respite all have a proportion of clients whose care needs are met, there is another large share whose needs are mostly met, and a significant minority whose needs are not met to a considerable extent. These results are similar to those from the separate survey on residential care⁴² that NARI conducted for the Royal Commission (Table 34).

Table 34: 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 areas' so columns are all mutually exclusive and equate to 100% across the row

If it is believed that the needs of people in aged care should be met all of the time, then around 77% of HCP clients, 86% of CHSP respite clients and 73% residential respite clients feel that some aspect of the quality of their care and service is failing them. If it is instead believed that the needs of these people should be met at least most of the time, then around 44% of HCP clients, 51% of CHSP respite clients and 46% of residential respite clients feel that some aspect of the quality of their care and service is failing them.

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. There is some evidence to suggest that people report being satisfied with their health care regardless of their experiences of care, even if they have had negative experiences^{43,44}. This is especially relevant to the older population⁴⁵, who may experience social desirability pressures and may be hesitant to express any concerns or displeasure about their services or care⁴⁶. The results of the present survey support this idea: although the majority of respondents answered 'always' to individual items about the quality of their care, only a minority answered 'always' to all items; approximately two-thirds identified at least one or more areas of concern in the subsequent Client Feedback Questionnaire; and clients said they often did not make their concerns known for reasons including fear of repercussions and not wanting to be a nuisance.

⁴² Batchelor et al., 2020

⁴³ Russell et al., 2020

⁴⁴ Haggerty, 2010

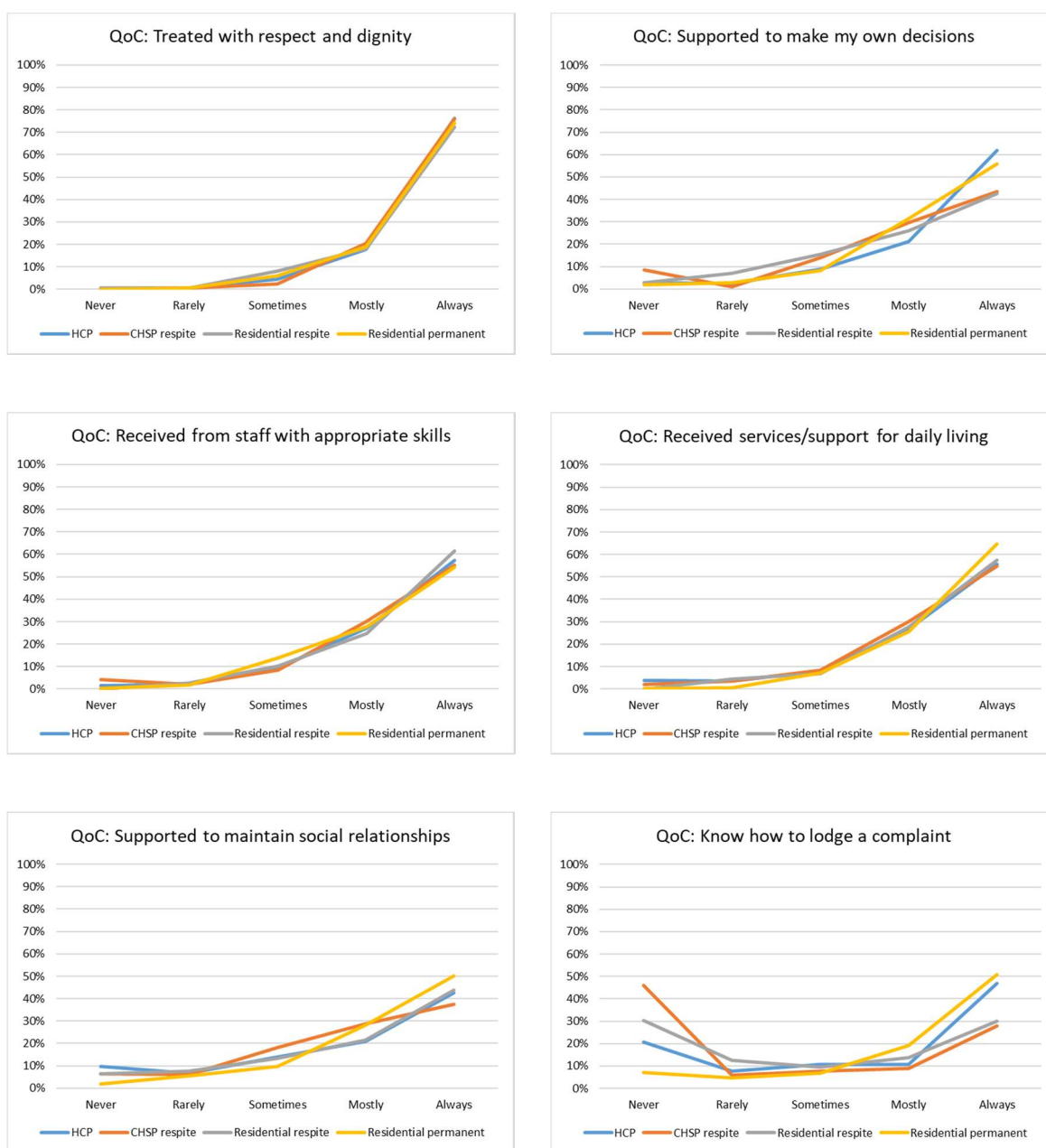
⁴⁵ Mold et al., 2012

⁴⁶ Batchelor et al., 2020

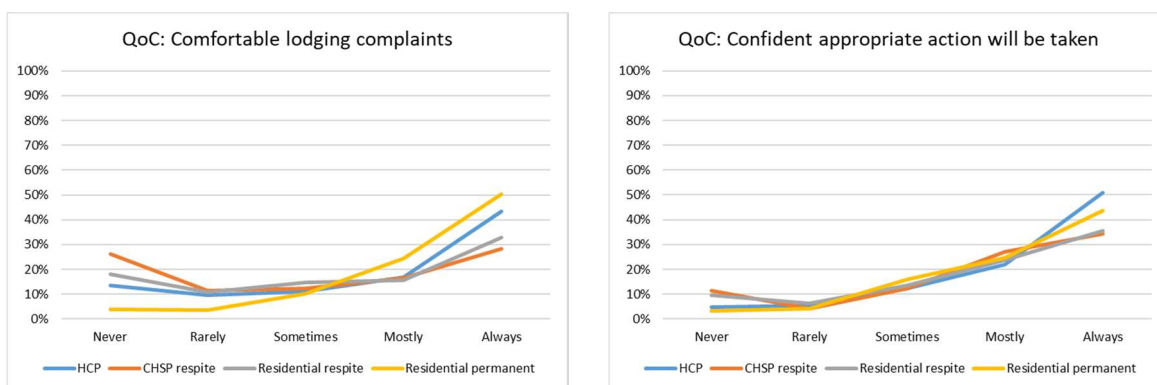
The results across the four care types are shown by individual domain in Figure 22⁴⁷. The results were very similar for being treated with respect and dignity (90% or over responded ‘always’ or ‘mostly’), and receiving care and support from appropriately trained aged care staff (80% or over responded ‘always’ or ‘mostly’). In the other domains, there were some notable differences across care types.

HCP, CHSP and residential respite clients responded that they ‘mostly’ or ‘always’ receive the services and supports for daily living that are important for their health and wellbeing less often compared with permanent residential aged care clients (82-85% vs 92.4%). This may be due to the more clinical and health-focused nature of services delivered in residential aged care. For those living in the community, services and supports for maintaining health and wellbeing are available in a more fragmented way.

Figure 22: Quality of care – individual domains by care type



⁴⁷ Results for the complaints domains of the questionnaire are discussed below.



HCP clients and permanent residential aged care clients also responded similarly to being supported to make their own decisions about the care and services they receive (both over 80% responded with ‘mostly’ or ‘always’), while CHSP and residential respite clients were less likely to feel this way (about 70% responded with ‘mostly’ or ‘always’). This may be due to the increased support provided to HCP and permanent residential clients and the ongoing nature of their services. CHSP and residential respite services are temporary and ‘ad hoc’ in many senses. These clients may not receive case management or other supports in the same way that HCP and permanent residential aged care clients do. Therefore, they are less likely to be supported to choose and make decisions about the types of care and services they receive. Considering the length of time that many people receive CHSP and residential respite services without other forms of support, it may be important to introduce access to some form of case management or increased support in order to enhance their ability to make decisions about their care. Given that the aged care system is so complex, difficult to navigate and there is inadequate information and support available to inform access to aged care services⁴⁸, one option would be to introduce case management services that are independent of service delivery providers⁴⁹. Independent case management could support aged care consumers to access and navigate the aged care system, to inform decisions about their care, and to locate appropriate services on a continuing basis.

HCP, CHSP and residential respite clients were less positive about being supported to maintain social relationships and community connections (58.7-67.3% for ‘mostly’ or ‘always’), compared to people receiving permanent residential care (78.3%). Social connections and social activities are potentially more available to people living permanently in residential aged care. In contrast, older people living in the community are often socially isolated and may have fewer options available for them to participate in social activities⁵⁰.

Clients can access a range of social support services through HCPs; however, there are questions about whether these services provide genuine opportunities for social and community connections. For example, ‘social support’ services often involve a home care staff member visiting the client or taking them out for shopping or for food. While this is a valuable service, the relationship between client and carer is ultimately a professional one; the staff member is performing a job, and the quality of any social connection that might arise will vary between individuals.

Lack of continuity of staff or high rates of staff turnover may also limit clients’ opportunities to develop meaningful connections with staff. There are also community social support groups available, and support to attend these can be provided through HCP and CHSP. However, these may be fragmented and difficult to access⁵¹, particularly as the availability of such support groups is highly variable across providers and regions.

⁴⁸ Phillipson, Low & Dreyfus, 2019

⁴⁹ COTA Australia, 2020

⁵⁰ COTA Australia, 2020

⁵¹ Russell et al., 2020

Furthermore, as clients move between different types of aged care support services, it can be difficult to maintain involvement. Centre-based respite services are available through CHSP, where clients can participate in activities and interact with other people. However, these services are also limited, and even less likely to be accessible during the ongoing COVID-19 pandemic. This was highlighted in the current study, where a very small proportion of CHSP respite clients had accessed centre-based respite.

For all of these reasons, there is a strong need for increased access and opportunity for HCP and respite clients to engage with others and enable development of meaningful social and community connections. Our results, along with the results of other studies, indicate that quality of care is insufficient for a significant minority of home and respite clients. As noted earlier, the aim should be for all clients to be appropriately cared for at all times.

7.2 Life satisfaction and quality

General life satisfaction at the time of the interview was, on average, moderately high across the HCP, CHSP and residential respite samples (GLS mean scores 7.2, 6.5 and 6.8, respectively; Figure 23). However, these GLS scores are below that of community-dwelling older adults in a large European study (SHARE survey; mean 7.6, SD 1.9)⁵², the wider Australian average of 7.3 reported by the OECD Better Life Index⁵³, and an average score above 8 for adults aged over 65 in the HILDA study⁵⁴. Within the HCP sample, GLS decreased with increased level of package (Figure 24). In our survey of permanent residential aged care⁵⁵, there was a higher mean GLS score (7.5) than in all groups in the current study. This may be due to the higher proportion of proxy interviews in the current study, as proxies are more likely to rate life satisfaction more negatively than the clients themselves⁵⁶.

Quality of life, as measured by the CASP-12, showed similar patterns to the life satisfaction measure. CASP-12 scores were significantly lower for the CHSP respite respondents (mean 31.7) compared to HCP (mean 34.2) and residential respite (mean 33.7) respondents. CASP-12 scores tended to decrease with increasing HCP levels, and proxies reported lower CASP-12 scores compared to clients for HCP, CHSP and residential respite clients. The scores were lower than those obtained in the SHARE survey (mean 36.7) and our survey of permanent residential aged care CASP-12 scores (mean 36.8)⁴⁴. Differences in CASP-12 scores between permanent residents and the cohorts in this current survey appear to be largely driven by more positive responses to viewing age as a constraining factor: permanent residents were less likely to consider age as a limiting factor.

Social care-related quality of life, as measured by the ASCOT-SCT4, was also moderately high for HCP, CHSP and residential respite clients (means 0.8, 0.7, and 0.8, respectively). There was a general decrease in SCRQoL in higher HCP levels. The SCRQoL scores were below those obtained from an Australian study of community-based older adults (mean 0.9, SD 0.1)⁵⁷. The ASCOT-SCT4 was not used in our residential care survey as it is not designed for that purpose⁵⁸.

Overall, CHSP respite respondents had significantly lower life satisfaction, quality of life and somewhat lower SCRQoL than did HCP and residential respite respondents. Client proxies were also less positive about the relief they gained from CHSP respite than were the proxies of people using residential respite services. People receiving CHSP generally receive less support than people with a HCP or people who are cared for in residential

⁵² Survey of Health, Ageing and Retirement in Europe, 2020

⁵³ OECD, 2017

⁵⁴ Ambrey & Fleming, 2013

⁵⁵ Batchelor et al., 2020

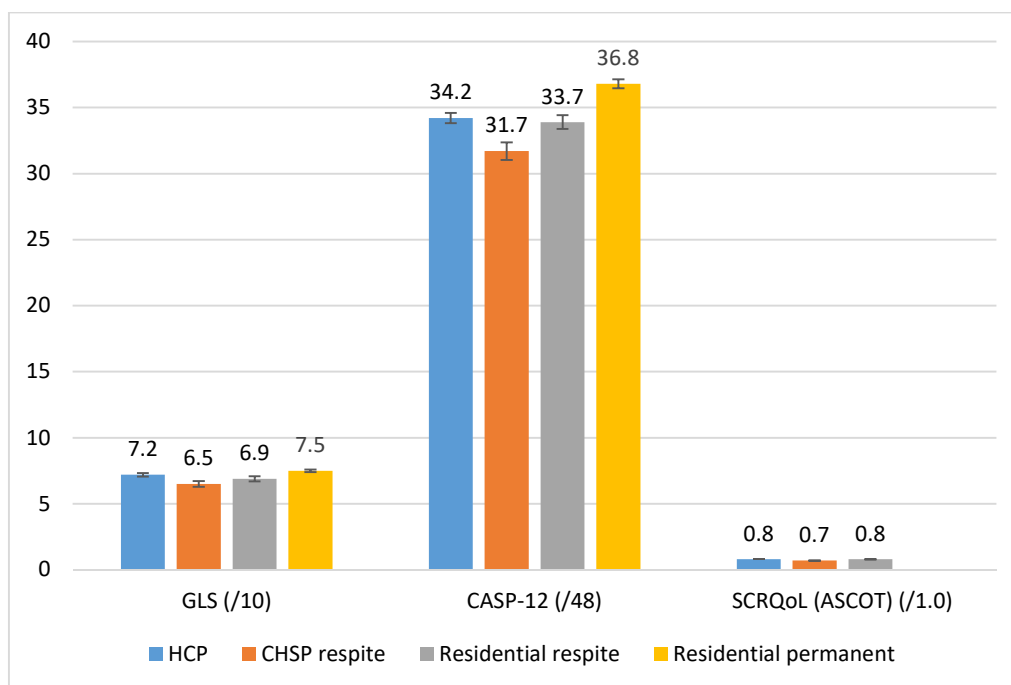
⁵⁶ Trigg et al., 2011

⁵⁷ Milte et al., 2014

⁵⁸ Personal Social Services Research Institute, 2020

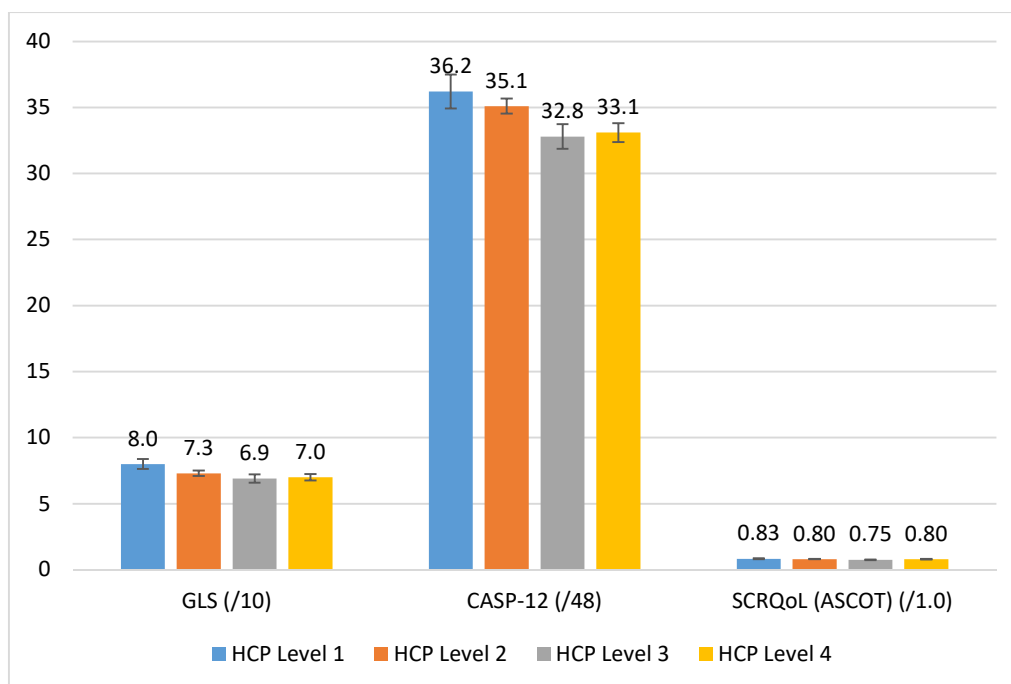
care (even if only temporarily). CHSP services are often accessed while an older person is waiting for a HCP; given the long waiting periods for HCPs, this may be impacting life satisfaction and quality for a significant population of people. This suggests that more investment needs to be made into resourcing regardless of level of care.

Figure 23: Life satisfaction and quality – HCP, CHSP respite, residential respite and residential permanent comparison



NB: ASCOT was not administered in the permanent residential care survey; bars represent 95% confidence interval

Figure 24: Life satisfaction and quality – HCP level comparison



NB: bars represent 95% confidence interval

7.3 Concerns

The prevalence of concerns among HCP and respite clients is relatively high. The average number of concerns for HCP clients was 4 (the same as among residential facility residents), for CHSP respite clients it was 3.5 and for residential respite clients it was 4.4. After respondents identified concerns, they were asked to select up to three 'main' concerns from all concerns identified. For HCP respondents, the average number of main concerns was 1.4, for CHSP respite and residential respite respondents it was 1.6, and for residential facility residents it was 4.

HCP clients on higher level packages were more likely to have a larger number of concerns as well as main concerns. This may be due to the increased number of services clients on higher level packages are receiving, and/or their familiarity with services and associated issues. With this increasing use of different services in higher HCP levels, there was an increase in both the proportion of clients that cited concerns, and in the overall number of domains of concern. For example, 9.1% of HCP Level 1 clients and 14.0% of Level 2 clients had concerns in four or more domains, compared with 29.6% and 23.8% of HCP Level 3 and Level 4 respectively. Whether higher level HCP clients have a similar number of concerns after taking into consideration their increased use of services across multiple types requires further analysis.

Both HCP and CHSP respite clients identified similar types of concerns (Figure 25). The most common concerns for both of these groups could be attributed to the domains of finance and administration, staffing, lack of choice, and services. For residential respite clients, the two domains of highest concern were services and fees and staffing. However, when considering individual items of concern, the most commonly cited concerns were understaffing, feeling lonely/bored, medication management, food/catering, and the call bell not being answered. These results for residential respite are comparable to the responses from permanent residential aged care residents in our previous survey. Permanent residents likewise listed understaffing, food/catering, feeling lonely or bored, and unanswered call bells in their top five concerns. Of note is that residential respite clients, compared to permanent residents, were more likely to identify concerns in lifestyle (12.5% vs 6.1%) and medication management (17.6% vs 7.0%). This may be due to the temporary nature of residential respite services. As respite clients are only living in a facility for a short period, they are probably less likely to be able to exercise choice, and quality of care may be somewhat impaired as the staff are not as familiar with their care needs and are less able to exercise person-centred care.

7.3.1 Finance and administration

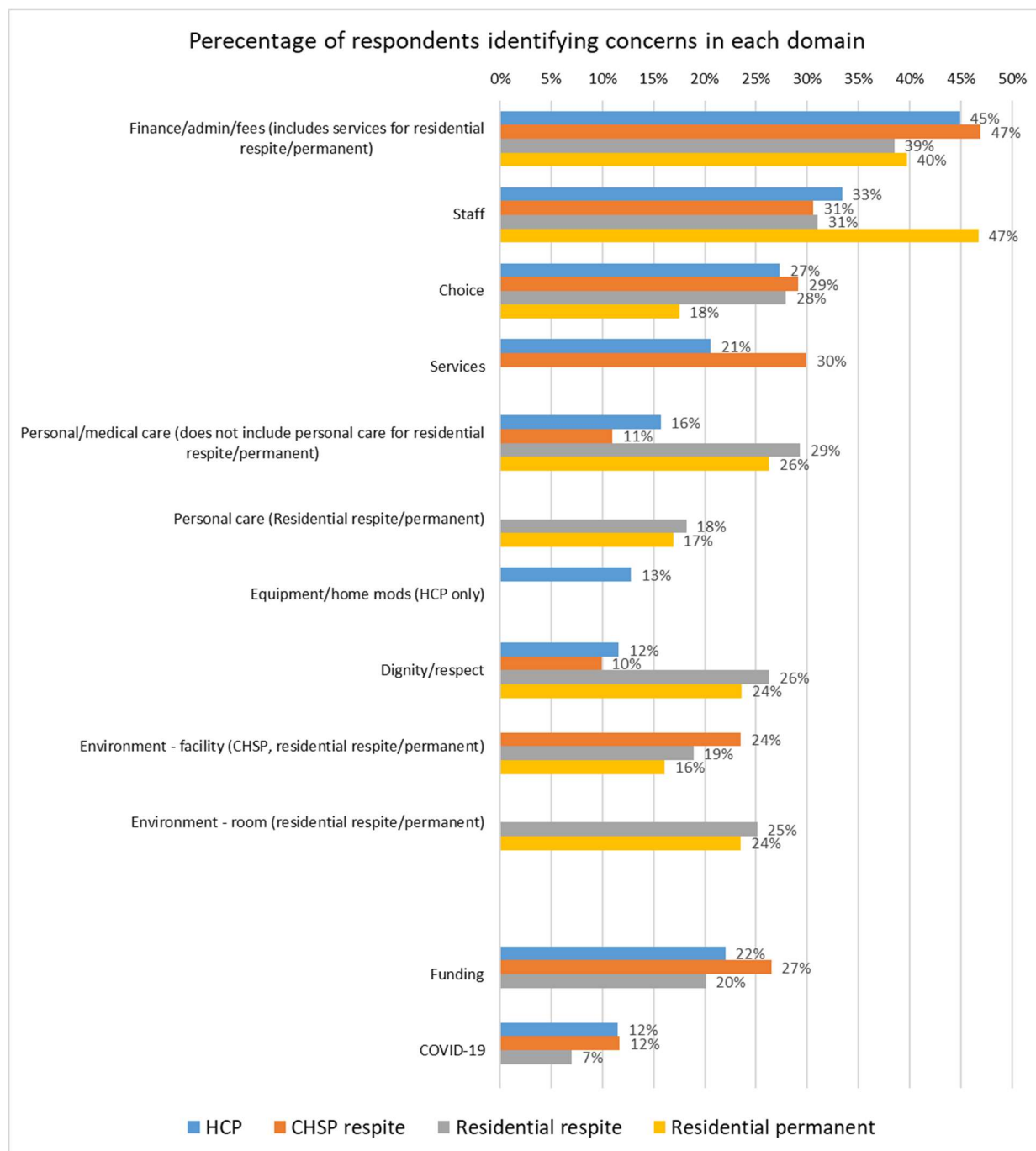
Almost half of all groups identified that finances and administration or fees and services was the predominant domain of concern, suggesting that regardless of whether care is in the home or in another aged care setting, a substantial proportion of aged care clients hold the same type of concern. For HCP clients, the top four most common concerns across any domain were all related to finance and administration: value for money, service coordination, invoicing and regular statements, and fee transparency. The other concerns in this domain related mainly to inadequate correspondence or information, case management, waiting times and services not being tailored to clients' needs. This was the same for CHSP respite clients (with the exception of monthly statements/invoicing and case management, which are not relevant for CHSP clients). Fees and charges were also a primary concern for residential respite clients and permanent residential clients.

Concerns relating to finance and administration for HCP, CHSP and residential respite clients have been previously identified. In Latrobe University's pilot study of the CER⁵⁹, 31.0% of clients felt that they were 'never' or only 'some of the time' satisfied with value for money of their CHSP or HCP services. This compares to 23.4% of all HCP clients and 25.7% of all CHSP clients in the current study. In the ACQSC's annual report detailing complaints submitted by home care clients from 2018-2019, fees and charges was also the most common

⁵⁹ Latrobe University, 2019

complaint identified. Clearly, the area of funding and administration of home care and respite services is one of the largest areas of concern for HCP and CHSP clients.

Figure 25: Concerns in each domain – comparison between care types



NB: Questionnaires were tailored to the type of care, so domains and individual items differ except for residential respite and residential permanent. Funding and COVID-19 items indicate the proportion of respondents who attribute concerns being impacted by their overall funding amount or COVID-19.

The prevalence of concerns in the area of funding reflect broad systemic issues in home and community care, and also more generally in the aged care sector. While the opening of the aged care market has been beneficial in some ways⁶⁰, increased government regulation is necessary. This would involve a much more active role of government, beyond funding and regulation based on simplistic quality standards. Government should ensure that: providers are more transparent in their finances and operations; aged care consumers are given clear and accessible information; consumers are given better support to navigate the system, make choices and obtain value; there is funding to commission or support specialist or innovative providers; and the system promotes service innovation and best practice that will maximise outcomes for older people⁶¹.

7.3.2 Staff

For HCP, CHSP respite and residential respite clients, concerns in the staff domain were the second most prevalent, whereas in our survey of permanent facility residents it was the most prevalent domain. For HCP and CHSP respite clients, the most common concerns about staff included continuity, staff not being adequately trained, poor communication between staff and staff not being on time or cancelling regularly. Staff continuity was also part of the concerns of residential respite clients and permanent facility residents but described as not seeing many familiar faces among staff, agency staff not knowing the client and their needs, or as high rates of staff turnover. Besides these continuity related concerns, the most common staff related concerns of residential respite clients and facility residents were understaffing, call bells not being answered, and inadequately trained staff.

While the importance of staff levels and training is well understood, staff continuity is less so. Casualisation can create problems such as staff being less able to learn the needs of each person in their care and build relationships with them; less incentive for providers to invest in skills development; and greater risk that clients might be exposed to illnesses from staff who would not be paid if they take a sick day. The problems from casualisation of the aged care workforce are then exacerbated by workforce shortages⁶², which has been demonstrated on a large scale during the 2nd wave of the COVID-19 pandemic when outbreaks occurred in many aged care facilities in Victoria. Both government and organisation level action is needed to address workforce issues to enable better continuity of care, an aspect that is important to many older people.

7.3.3 Choice

Lack of choice was also a key area of concern for HCP, CHSP respite and residential respite clients, as it was for permanent residents but to a lesser extent. For HCP clients, the most common concerns about choice included lack of clarity about entitlements, not being able to choose who provides the services, and not being able to negotiate costs. These are all fundamental aspects of choice that the aged care system should be expected to achieve, especially to HCP clients since the program is predicated on the clients deciding how to allocate their own budget.

CHSP respite clients, by nature of the CHSP program, have very few choices when it comes to their care. They can only choose from a limited set of services from a limited range of providers, and without much flexibility⁶³. Despite this, concerns about choice among this group were less than 2 percentage points higher than for HCP clients, and the nature of the concerns were similar.

Recent reforms to the aged care sector position aged care recipients as ‘consumers’ who are able to choose between services on the basis of the perceived quality of those services⁶⁴. The positioning of older people

⁶⁰ Davidson, 2018

⁶¹ Brotherhood of St Laurence, 2019

⁶² PwC, 2019

⁶³ COTA Australia^b, 2020

⁶⁴ Henderson & Willis, 2020

accessing aged care services as ‘consumers’ is problematic as it can diminish their rights as citizens and decrease government responsibility to provide support and advice⁶⁵. The positioning as consumers suggests older people have the money or funding to choose the best services to meet their needs and expectations, that they understand what their choices entail and that they are able to search for alternatives and make further choices if they decide that their service is unsatisfactory. However, some older people have less capacity to choose or switch between aged care services, due to factors which may make them more vulnerable than the general population. Additionally, ‘consumers’ may not have access to the information necessary to determine the potential quality of aged care services before making a choice. This was demonstrated in a recent study, which determined that resources available to aged care clients are inadequate to assist people to make choices under the consumer directed care model⁶⁶. The quality and accessibility of information and support to enable decision-making for older people accessing aged care services needs to be improved if a market model is to be effective.

For residential respite clients and permanent residents, the most common concerns in the choice domain were around aspects of direct care, for example not having enough lifestyle activities to choose from, personal care and the timing of meals. It is apparent that while HCP and CHSP clients tend to be more concerned about administrative and system issues around their ability to make choices, such as lack of information and the amount of alternatives to choose from, clients accessing permanent or respite residential aged care tend to be more concerned about being able to choose specific aspects of the care being provided to them.

7.3.4 Services

Services were another key domain of concerns for all groups in the study; however, this domain included different aspects of service for each group. For HCP clients, most concerns in this area were related to domestic assistance/cleaning (a concern for 12.5% of clients though used by 90%), as well as transport and social support. For CHSP clients, most of these concerns were related to loneliness and boredom (16.8% of clients), transport, connection to the community, meal preparation, and activities. Residential respite clients and permanent facility residents were mostly concerned about feeling lonely or bored and the food experience (over 16% of both client groups), but also lifestyle activities, laundry services, fees and charges, and social engagement. Changes to how aged care is regulated and funded may improve performance in some of these areas of concern by setting clearer performance standards and resourcing obligations. However, others are more complex to solve, such as social isolation and loneliness – these are highly prevalent in the older population, with detrimental health effects, and require targeted interventions⁶⁷.

7.3.5 Personal, medical and health care

For HCP clients, concerns related to personal or medical care were held by 15.7% of the sample. These concerns included mobility and falls prevention, medical care (e.g. continence, wounds and pain), accessing allied health professionals, and showering, grooming and dressing. The prevalence of concerns in this domain was lower for CHSP respite clients (11.0% of clients), with the most common concern being showering, grooming or dressing. The rate of concerns in this domain were much higher for residential respite clients; for this group the domain was separated into two, medical and health care/personal care, which had concerns for 29.3% and 18.2% of clients respectively. Medical and health care concerns also featured strongly among permanent residential aged care clients (26.3% of the sample), with falls and falls prevention, medication management and seeing a GP when needed being of concern. Concerns about personal care were also featured in this sample. Personal, medical and health care are fundamental components of aged care. It is

⁶⁵ Fine & Davidson, 2018

⁶⁶ Phillipson & Dreyfus, 2019

⁶⁷ National Academies of Sciences, Engineering, and Medicine, 2020

important to address the shortcomings in the areas, especially in residential aged care facilities given the residents generally have little or no capacity to access community health services by themselves.

7.3.6 Dignity and respect

Dignity and respect was a common domain of concern for residential respite and permanent residents (24% or more of clients in these groups) but less so for HCP or CHSP respite clients (12% or less). The most common concerns in this domain for all four care types were not being allowed to do certain things (or forced to be dependent on staff), not having needs and wishes considered, and being treated like a child. All four care types also had small shares of clients report concerns about continence pads (e.g. forced use, insufficient supply or changing) and being shouted at by staff. While concerns about dignity and respect were not as prevalent as concerns in other domains, any concerns in this domain are a problem and something that urgently needs to be addressed.

7.3.7 Respite environment

The respite environment domain refers to the characteristics of place where respite occurs i.e. not in one's own home. This is centre-based or community based respite environments for CHSP clients and residential aged care facility environments for residential respite clients. Of all CHSP clients, 23.5% were concerned about the environment in which they received respite services. For residential respite clients, 25.1% were concerned about aspects of their room within the facility. This included things like noise, privacy, cleanliness, security and feeling safe. Residential respite clients were less concerned about the facility environment in general (18.9% of respondents), but some felt concerned about noise, cleaning and maintenance of equipment, furniture and gardens and overall safety. Permanent residents of aged care facilities reported similar levels of concern in this area in our previous survey, with more of the sample being concerned about their room than the facility overall. Environmental factors have the potential to either substantially benefit or negatively impact people living in or accessing respite in aged care facilities. Where the environment is substandard, design or refurbishment initiatives have the potential to maximise positive health outcomes for older people⁶⁸.

7.3.8 Concerns related to funding issues

Many respondents did not differentiate between lack of funding allocated to their own services and lack of funding to the aged care sector, which may reflect the complexity of the aged care system and difficulties clients may have in understanding it. The results of these questions should therefore be interpreted cautiously. The proportion of main concerns that respondents identified as being the result of funding issues was relatively consistent between the service groups (22.5%, 26.5% and 20.0% for HCP, CHSP respite and residential respite respectively), however clear differences emerged regarding the areas of concern that were most affected. HCP and CHSP respite clients indicated they thought that funding issues most often affected finances and administration of their services, in particular, transparency around fees and charges, and the amount of administration fees. Funding issues for residential respite clients were believed to more often underpin main concerns about direct care (e.g. the available services and staffing levels). These findings suggest that systemic barriers to provision of aged care that are due to or result from inadequate funding manifest themselves in different ways for those receiving HCP and CHSP respite compared to those receiving residential respite. Because their services are built on the premise of consumer-directed care and self-management of services to suit individual needs, HCP clients and their representatives have particular expectations regarding their level of involvement in the management of their services and funding; however, this is often complicated by system complexity and lack of transparency in fees and invoicing.

⁶⁸ Neylon & Hill, 2019

7.3.9 COVID-19 related concerns and impacts

The survey was undertaken during the COVID-19 pandemic and associated restrictions and around 60% of all respondents were impacted by the situation. HCP clients identified 7.1% of their concerns were due to COVID-19 and CHSP respite clients identified 11.7%. Only 3.5% of residential respite clients' main concerns were said to be the result of COVID-19, which may be because they had their respite experiences prior to the pandemic and may not have accessed this service during periods of restriction. In contrast, HCP and CHSP respite are ongoing services that clients were more likely to have accessed during the COVID-19 pandemic, despite the lists we used to sample clients for these groups being less current than for residential respite.

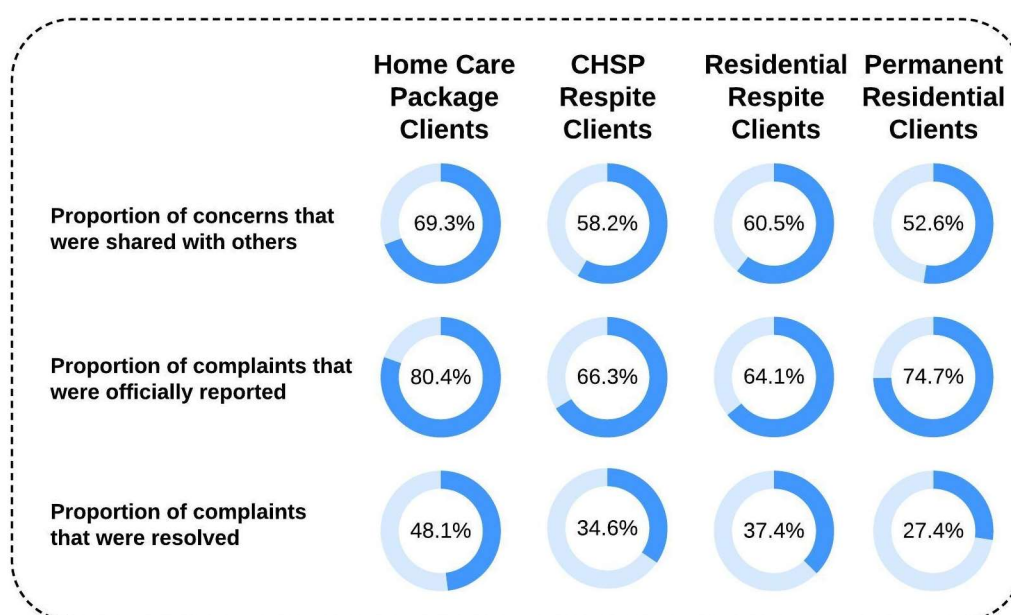
Staffing was a consistent area of concern affected by COVID-19 across all service types. Some respondents said that providers were understaffed or unable to provide continuous staffing due to staff members having family responsibilities, self-isolation requirements or being uncomfortable with the working environment. HCP and CHSP respite clients had concerns about the fees and service administration when providers cut back on provision of services or clients chose to reduce services to minimise contact with others, feeling that the fees did not reflect reduced services. Loneliness and a lack of activities to choose from were also consistent main concerns resulting from COVID-19.

As noted earlier, the longer term impacts of COVID-19 are unknown but are likely to be far-reaching, particularly as the pandemic continues and restrictions have been re-introduced in some parts of Australia. Access to services may be further limited or not available at all, for example outbreaks in aged care facilities will impact availability of residential respite services. Government and industry need a comprehensive plan to understand and address any downstream issues for HCP, CHSP respite and residential respite clients.

7.4 Reporting and resolution of complaints

Despite the prevalence of concerns, it is apparent that many are not discussed with anyone at all. Of all main concerns identified by participants, the proportions not discussed with anyone were 30.6% in HCP, 41.8% in CHSP respite, 39.5% in residential respite, and 47.3% in permanent residential care (Figure 26).

Figure 26: Reporting and resolution of complaints by care type



For HCP clients, the most common reasons cited for not discussing concerns with others were that they did not think anything would change, that the concern was too minor, that they did not want to be a nuisance or make a fuss, or that they weren't sure who to report to. Clearly, the HCP system, as well as the system for

making complaints in aged care, is too complex and difficult to navigate for many, and many HCP clients do not feel empowered to raise concerns about the quality of their care or other issues. The results also reflect the limitations that HCP clients face in making choices and decisions about their care. Action is needed to empower aged care clients and encourage them to speak up about their concerns. Reform is also needed to simplify and improve the system for raising and resolving concerns.

For both CHSP and residential respite clients, the main reasons cited for not sharing concerns included that they only received the service for a short time and it was not worth complaining, that they did not have the capacity to complain, or that they did not want to be a nuisance or make a fuss. Permanent residents of aged care facilities expressed similar reasons for not sharing their concerns, but rather than withhold their concerns because the service was for a short time, they withheld concerns because they did not think anything would change if reported it (and indeed the lack of satisfactory resolution is reflected in other results from the survey). As for HCP, a better system needs to be established for assessing quality in these care types and any concerns that clients may have about services, even if only accessed for a short period of time.

Of the main concerns which were reported, around two thirds were discussed by HCP clients with others unofficially (mostly with family and friends), while just over half were officially reported (mostly to staff or the provider, only 0.1% to the ACQSC). This was similar for both CHSP and residential respite clients – around two thirds reported their concerns unofficially (mostly to family and friends), though just one third were reported officially (mostly to aged care staff or the respite provider, none to the ACQSC). Permanent residents in aged care facilities had higher official reporting rates than for HCP and respite clients (around three-quarters, none to the ACQSC) and lower unofficial reporting (around one-quarter). The very low level of reporting to ACQSC in our surveys is consistent with the ACQSC's own statistics. For example, a total of 1552 complaints were made to the ACQSC in 2018-2019 about HCP services⁶⁹ and, as of June 2019, there were around 125,000 HCP clients in total. Clearly, official processes for reporting complaints are not capturing the extent of concerns that HCP and respite clients are experiencing.

The questions about complaints in the Quality of Care questionnaire help explain why official reporting was lowest among respite clients (Figure 22 presented above). CHSP respite and residential respite clients are far less likely to have knowledge about the complaints process, to feel comfortable in lodging complaints, and to feel confident that action would be taken in response to their complaint. This may be due to the temporary nature of their services, and/or because they are not supported as much as HCP and permanent residential care clients in their care. HCP clients generally have access to case management services, through which they may be able to express concerns and complaints. Case management also increases the likelihood that concerns or complaints are followed up and that actions will be taken to resolve them. Similarly, those living permanently in residential aged care are in close proximity to a wide range of staff members, and presumably can raise their concerns more easily than those more at distance from direct care or management staff (including HCP, CHSP and residential respite clients). As aged care clients living in the community are, in many senses, distanced from providers and often feel unable to report their concerns, increased measures are needed to engage them and empower them to speak up about any concerns they may be experiencing or have experienced.

Less than half of the officially reported complaints in all four care types were resolved to the client's satisfaction. Reasons for this included that nothing changed, they were still waiting for resolution, at first things changed but then things reverted back, or that some action was taken but not enough. Clearly, the system for complaints in aged care is not working. This was highlighted in the Royal Commission's Interim report, as many residential and home care clients indicated 'that the complaints system is hard to access, slow

⁶⁹ Aged Care Quality and Safety Commission, 2019

to act and often effectively unresponsive to the concerns of the complainant⁷⁰. A more effective and efficient system for identifying and resolving complaints and even minor concerns is needed. This may involve improved systems at the organisation level (e.g. processes for measuring quality and concerns and other continuous improvement initiatives) and at the broader level (e.g. increased involvement of the ACQSC).

The ACQSC, which has been described as ‘difficult to access and slow to respond’⁷¹, needs to change its nature. The results of this study indicate that most aged care clients are not reporting their concerns to the ACQSC (nearly 1.0% of HCP clients officially made complaints to the ACQSC and clients in the other groups made none). While the ACQSC performs an important role in the regulation of aged care services, its focus on accreditation standards and reporting obligations represents a minimal, rather than optimal focus on quality⁷². 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 families⁷³.

7.5 Looking to the future

To the best of our knowledge, our surveys of residential, home care and respite care are the first studies in Australia to have quantitatively examined in detail how aged care recipients 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 in recent decades. The next wave of reform to aged care will, we hope, correct that balance and optimise care quality.

Surveys like ours enable society to see for itself, the areas where improvement is needed, and provide a benchmark by which 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.

⁷⁰ Royal Commission into Aged Care Quality and Safety, 2019

⁷¹ Royal Commission into Aged Care Quality and Safety, 2019

⁷² Victorian Government, 2019

⁷³ Victorian Government, 2019

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9 Appendices

9.1 Client Feedback Questionnaires

Table 35: HCP Client Feedback Questionnaire

In the last six months, have you had any concerns or complaints about:	
Management, finances and administration	• Case management • Service coordination/rostering • Inadequate correspondence or information • Services not tailored to my needs • Value for money (e.g. fees too high) • Transparency around fees & charges • Monthly statements/invoicing • Waiting time for funds/services/reimbursements • Or any other concerns about finances and administration?
Services	• Respite • Domestic assistance/cleaning • Meal preparation • Transport • Social support/activities that are enjoyable • Or any other concerns about services?
Personal or medical care	• Accessing personal care services • Accessing nursing services • Accessing other health professionals (e.g. allied health) • Showering, grooming or dressing • Assistance with eating • Assistance with toileting • Mobility and falls prevention • Medical (e.g. continence, wounds, pain) • Medication management • General health and wellbeing management • Or any other concerns about personal or medical care
Equipment, home maintenance or home modification services?	• Goods, equipment & assistive technology • Home maintenance (keeping the home & garden safe) • Home modifications (changes to improve safety & access) • Or any other concerns about equipment, home maintenance or home modification?
Home care staff	• Home care staff attitudes (e.g. unkind, rude, unhappy) • Home care staff conduct • Home care staff turnover/inconsistency • Staff not adequately trained

In the last six months, have you had any concerns or complaints about:	
	• Poor communication between home care and other staff • Home care staff badge not displayed • Staff not culturally sensitive or are mismatched • Being hurt or treated roughly by staff • Staff not on time/cancel regularly • Or any other concerns about home care staff
Not being treated with dignity and respect	• Not being allowed to do certain things • Shouted at by staff • Lack of an individualised care plan • Needs and wishes not considered • Or any other concerns about being treated with dignity and respect
Being given enough choice	• Independence not supported e.g. not able to leave the house • Lack of choices about social interaction • Lack of activities to choose from • Not included in planning/decision making • Not able to choose required services • Not able to choose when and how services are provided • Not able to choose who provides services • Not able to negotiate costs • Lack of clarity about entitlements • Or any other concerns about being given enough choice

Table 36: CHSP Respite Client Feedback Questionnaire

In the last six months, have you had any concerns or complaints about:	
Finances and Administration	• Service coordination/rostering • Inadequate correspondence or information • Services not tailored to my needs • Value for money (e.g. fees too high) • Transparency around fees & charges • Or any other concerns about finances and administration?
Services	• Meal preparation • Activities that are enjoyable • Being connected with the community • Transport • Loneliness and boredom
Staff	• Staff attitude, body language or conduct, like staff being unkind, rude, or unhappy • Continuity of staff

In the last six months, have you had any concerns or complaints about:	
	• Staff not being adequately trained • Poor communication between staff • Staff badge/role not displayed • Staff not being culturally sensitive (caring about my beliefs, values, spirituality, customs or religion) • Being hurt or treated roughly by staff • Use of restraint • Staff not on time/ cancel regularly • Staff being mismatched to my preferences (e.g. not preferred gender) • Or any other concerns about home care staff?
Not being treated with dignity and respect	• Not being allowed to do certain things • Being treated like a child • Continence pads (e.g. forced use, insufficient supply or changing) • Being shouted at by staff • Needs and wishes not considered • No individualised care plan (CHSP) • Not being informed of daily routine (CHSP) • Or any other concerns about being treated with dignity and respect?
Being given enough choice	• Independence not supported e.g. not able to leave the house • Lack of choices about social interaction • Lack of activities to choose from • Not included in planning/decision making • Not able to choose required services • Not able to choose when and how services are provided • Not able to choose who provides services • Lack of clarity about what I am entitled to • Or any other concerns about being given enough choice?
Personal or medical care	• Showering, grooming or dressing • Assistance with eating • Assistance with toileting • Mobility and falls prevention • Medical (e.g. continence, wounds, pain) • Or any other concerns about personal or medical care?
Respite environment	• Feeling safe in the respite facility • The security of the respite facility • Cleanliness and maintenance of the respite facility • Noise • Privacy

In the last six months, have you had any concerns or complaints about:	
	• Or any other concerns about the respite facility?

Table 37: Residential Respite Client Feedback Questionnaire

In the last six months, have you had any concerns or complaints about?	
Not being treated with dignity and respect	• Not being able to do certain things • Being treated like a child • Continence aids e.g. • No individualise care plan • Not being informed of daily routine • Being shouted at by staff • Or any other concerns about dignity and respect?
Personal care	• 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?
Medical and health care	• Seeing a GP when needed • 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 • Or any other concerns about medical and health care?
The choices available to you	• Not being allowed out of bed/chair/room, or not being allowed outside • Choices about how and when you interact with other clients • 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?

In the last six months, have you had any concerns or complaints about?	
Staff	• Staff attitude, body language or conduct, like staff being unkind, rude, or unhappy • Staff culture or facility culture (how staff work together or treat each other) • Staff name/badge not displayed • 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?
Your room	• 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 • Or any other concerns about your room?
The facility	• 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?
Services	• 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?

9.2 Additional results

9.2.1 HCP clients results

Table 38: Demographic characteristics of HCP clients by level

Characteristic	HCP Level	Category	n (unweighted)	Unweighted %	Weighted %
Sex	Level 1	Female	101	68.7%	69.7%
		Male	46	31.3%	30.3%
	Level 2	Female	192	67.1%	66.1%
		Male	94	32.9%	33.9%
	Level 3	Female	135	66.5%	65.9%
		Male	68	33.5%	34.1%
	Level 4	Female	160	69.9%	70.5%
		Male	69	30.1%	29.5%
Age (years)	Level 1	45-54	0	0%	0%
		55-64	3	2.0%	2.2%
		65-74	24	16.3%	16.9%
		75-84	74	50.3%	49.4%
		85-94	45	30.6%	30.3%
		95+	1	0.7%	1.1%
		Prefer not to say	0	0%	0%
	Level 2	45-54	0	0%	0%
		55-64	7	2.4%	1.8%
		65-74	36	12.6%	12.3%
		75-84	127	44.4%	44.6%
		85-94	108	37.8%	38.1%
		95+	6	2.1%	2.2%
		Prefer not to say	2	0.7%	1.15
	Level 3	45-54	1	0.5%	0.5%
		55-64	2	1.0%	1%
		65-74	41	20.2%	20.5%
		75-84	83	40.9%	40.5%
		85-94	70	34.5%	34.6%
		95+	6	3.0%	2.9%
		Prefer not to say	0	0%	0%
	Level 4	45-54	2	0.9%	0.7%
		55-64	2	0.9%	0.7%
		65-74	45	19.7%	19.5%
		75-84	85	37.1%	37.3%
		85-94	81	35.4%	36%
		95+	14	6.1%	5.9%
		Prefer not to say	0	0%	0%
HCP Duration	Level 1	Less than 1 year	54	36.7%	37.1%
		1-2 years	69	46.96%	47.2%
		3-5 years	20	13.6%	13.5%
		6+ years	2	1.4%	1.1%
		Don't know	2	1.4%	1.1%
	Level 2	Less than 1 year	39	13.6%	14%
		1-2 years	163	57.0%	56.9%
		3-5 years	65	22.7%	23.2%
		6+ years	16	5.6%	4.8%
		Don't know	3	1.0%	1.1%

Characteristic	HCP Level	Category	n (unweighted)	Unweighted %	Weighted %
	Level 3	Less than 1 year	28	13.8%	12.7%
		1-2 years	103	50.7%	51.0%
		3-5 years	60	29.6%	30.4%
		6+ years	11	5.4%	5.4%
		Don't know	1	0.5%	0.5%
	Level 4	Less than 1 year	14	6.1%	5.9%
		1-2 years	83	36.2%	38.0%
		3-5 years	88	38.4%	38.6%
		6+ years	40	17.5%	15.8%
		Don't know	4	1.7%	1.7%

Table 39: Quality of care – All HCP clients

	Never	Rarely	Sometimes	Mostly	Always	Don't know	Prefer not to say
Treated with respect and dignity	0.2%	0.7%	4.5%	17.8%	76.3%	0.6%	0.0%
Supported to make my own decisions about the care and services I receive	2.9%	2.6%	8.8%	21.3%	61.9%	2.3%	0.2%
Received care and support from aged care staff who have the appropriate skills and training	1.6%	2.2%	9.3%	27.2%	57.2%	2.3%	0.2%
Received services and support for daily living that are important for my health and wellbeing	3.8%	3.6%	8.1%	26.7%	55.6%	2.3%	0.0%
Supported to maintain my social relationships and connections with the community	9.6%	6.7%	13.9%	20.8%	42.7%	5.8%	0.5%
Know how to lodge a complaint	20.7%	7.6%	10.6%	10.7%	47%	3.2%	0.2%
Comfortable lodging complaints	13.6%	9.7%	11.0%	16.7%	43.5%	4.4%	1.1%
Confident that appropriate action will be taken when I make a complaint	4.8%	5.3%	12.4%	22.1%	51.0%	3.8%	0.5%

Table 40: Quality of care – HCP1 clients

	Never	Rarely	Sometimes	Mostly	Always	Don't know	Prefer not to say
Treated with respect and dignity	0.0%	1.5%	5.1%	15.9%	77.5%	0.0%	0.0%
Supported to make my own decisions about the care and services I receive	3.5%	2.0%	5.2%	26.6%	59.2%	2.8%	0.6%
Received care and support from aged care staff who have the appropriate skills and training	3.3%	5.3%	6.1%	21.9%	58.1%	5.3%	0.0%

	Never	Rarely	Sometimes	Mostly	Always	Don't know	Prefer not to say
Received services and support for daily living that are important for my health and wellbeing	8.1%	5.7%	12.0%	25.1%	46.0%	3.1%	0.0%
Supported to maintain my social relationships and connections with the community	8.0%	6.1%	16.2%	19.2%	43.4%	6.3%	0.9%
Know how to lodge a complaint	16.8%	7.0%	17.5%	10.2%	41.9%	5.8%	0.6%
Comfortable lodging complaints	12.5%	12.1%	16.8%	13.5%	37.7%	6.8%	0.6%
Confident that appropriate action will be taken when I make a complaint	6.1%	7.2%	12.8%	16.1%	51.0%	6.6%	0.0%

Table 41: Quality of care – HCP2 clients

	Never	Rarely	Sometimes	Mostly	Always	Don't know	Prefer not to say
Treated with respect and dignity	0.3%	0.8%	3.3%	16.0%	78.6%	0.8%	0.0%
Supported to make my own decisions about the care and services I receive	2.4%	2.5%	6.2%	16.5%	69.8%	2.5%	0.0%
Received care and support from aged care staff who have the appropriate skills and training	1.6%	1.1%	7.2%	26.3%	60.3%	3.5%	0.0%
Received services and support for daily living that are important for my health and wellbeing	4.1%	4.7%	7.6%	26.5%	53.7%	3.4%	0.0%
Supported to maintain my social relationships and connections with the community	8.7%	4.1%	13.1%	21.2%	46.4%	6.2%	0.3%
Know how to lodge a complaint	19.3%	7.4%	9.3%	8.6%	53.2%	2.3%	0.0%
Comfortable lodging complaints	12.1%	8.0%	9.0%	14.3%	50.3%	4.4%	1.9%
Confident that appropriate action will be taken when I make a complaint	2.7%	3.7%	9.6%	21.9%	56.6%	4.4%	1.1%

Table 42: Quality of care – HCP3 clients

	Never	Rarely	Sometimes	Mostly	Always	Don't know	Prefer not to say
Treated with respect and dignity	0.0%	1.0%	5.3%	15.4%	78.2%	0.0%	0.0%
Supported to make my own decisions about the care and services I receive	3.7%	2.8%	12.4%	23.6%	55.3%	2.2%	0.0%

	Never	Rarely	Sometimes	Mostly	Always	Don't know	Prefer not to say
Received care and support from aged care staff who have the appropriate skills and training	1.8%	3.3%	12.9%	28.9%	51.8%	1.2%	0.0%
Received services and support for daily living that are important for my health and wellbeing	5.5%	2.4%	8.9%	24.4%	57.8%	1.1%	0.0%
Supported to maintain my social relationships and connections with the community	10.9%	9.2%	16.3%	22.6%	35.8%	4.6%	0.6%
Know how to lodge a complaint	23.3%	10.9%	9.3%	13.8%	39.8%	3.0%	0.0%
Comfortable lodging complaints	16.3%	15.0%	11.6%	14.2%	38.6%	3.2%	1.2%
Confident that appropriate action will be taken when I make a complaint	8.9%	8.7%	16.9%	21.8%	41.6%	2.1%	0.0%

Table 43: Quality of care – HCP4 clients

	Never	Rarely	Sometimes	Mostly	Always	Don't know	Prefer not to say
Treated with respect and dignity	0.0%	0.0%	5.4%	22.8%	71.4%	0.5%	0.0%
Supported to make my own decisions about the care and services I receive	2.9%	2.5%	11.4%	25.4%	55.4%	1.9%	0.5%
Received care and support from aged care staff who have the appropriate skills and training	0.9%	1.9%	10.9%	29.3%	55.9%	0.5%	0.5%
Received services and support for daily living that are important for my health and wellbeing	0.9%	2.4%	7.1%	29.2%	59.4%	0.9%	0.0%
Supported to maintain my social relationships and connections with the community	10.7%	9.1%	13.0%	19.6%	41.4%	5.7%	0.5%
Know how to lodge a complaint	22.3%	6.1%	11.1%	11.8%	44.1%	4.1%	0.5%
Comfortable lodging complaints	14.7%	7.9%	11.8%	22.7%	38.5%	4.4%	0.0%
Confident that appropriate action will be taken when I make a complaint	4.8%	4.8%	13.5%	24.5%	49.0%	3.4%	0.0%

Table 44: CASP-12 responses – HCP clients

CASP-12 Item	Response	HCP1-4 (%)	HCP1 (%)	HCP2 (%)	HCP3 (%)	HCP4 (%)
My age prevents me from doing the things I would like to	Often	45.3	34.9	39.2	52.8	52.5
	Sometimes	30.7	37.3	34.9	25.0	26.4
	Rarely	12.1	11.3	16.4	6.3	9.7
	Never	11.2	15.3	9.4	15.3	9.7
	Not applicable / don't know	0.7	1.3	0.1	0.5	1.7
	Prefer not to say	0.0	0.0	0.0	0.0	0.0
I feel that what happens to me is out of my control	Often	27.3	13.5	20.6	34.6	36.7
	Sometimes	31.0	30.4	33.8	30.2	27.4
	Rarely	18.9	22.9	22.8	14.6	14.6
	Never	21.0	30.9	20.4	19.6	20.0
	Not applicable / don't know	1.6	2.3	2.0	1.0	1.3
	Prefer not to say	0.2	0.0	0.5	0.0	0.0
I feel left out of things	Often	15.0	10.5	13.4	20.1	15.2
	Sometimes	33.5	23.4	35.0	30.7	36.1
	Rarely	18.2	24.8	18.0	19.0	15.9
	Never	32.6	40.6	33.3	29.1	31.7
	Not applicable / don't know	0.7	0.6	0.4	1.0	1.1
	Prefer not to say	0.0	0.0	0.0	0.0	0.0
I can do the things that I want to do	Often	32.9	44.4	35.4	30.9	26.9
	Sometimes	36.7	34.1	39.5	31.6	36.9
	Rarely	18.3	14.1	15.0	25.6	19.4
	Never	11.1	6.8	9.3	11.4	15.1
	Not applicable / don't know	0.8	0.6	0.4	0.5	1.7
	Prefer not to say	0.2	0.0	0.5	0.0	0.0
Family responsibilities prevent me from doing what I want to do	Often	6.6	7.8	5.1	7.7	7.7
	Sometimes	16.8	22.4	19.8	17.7	9.9
	Rarely	17.9	17.5	20.6	14.6	16.3
	Never	56.3	50.1	53.0	56.1	63.1
	Not applicable / don't know	2.5	2.2	1.5	3.9	3.0
	Prefer not to say	0.0	0.0	0.0	0.0	0.0
Shortage of money stops me from doing the things I want to do	Often	14.2	18.1	13.3	14.9	13.9
	Sometimes	25.7	26.1	32.2	26.9	14.9
	Rarely	17.7	19.0	18.4	16.4	17.2
	Never	41.7	35.4	35.3	41.4	53.5

CASP-12 Item	Response	HCP1-4 (%)	HCP1 (%)	HCP2 (%)	HCP3 (%)	HCP4 (%)
	Not applicable / don't know	0.7	1.4	0.7	0.5	0.5
	Prefer not to say	0.0	0.0	0.0	0.0	0.0
I look forward to each day	Often	56.3	66.1	62.4	54.8	45.1
	Sometimes	28.5	22.0	27.5	22.4	36.1
	Rarely	9.2	5.2	5.7	14.9	11.9
	Never	4.5	4.9	3.2	5.2	5.7
	Not applicable / don't know	1.2	1.8	0.8	2.2	1.1
	Prefer not to say	0.3	0.0	0.5	0.6	0.0
I feel that my life has meaning	Often	49.6	62.5	55.0	43.8	41.3
	Sometimes	29.7	24.0	27.7	27.1	36.3
	Rarely	12.0	9.0	9.1	17.5	13.8
	Never	6.4	3.6	5.9	8.7	6.4
	Not applicable / don't know	1.9	1.0	1.5	2.9	2.2
	Prefer not to say	0.4	0.0	0.8	0.0	0.0
On balance, I look back on my life with a sense of happiness	Often	64.6	61.8	67.2	61.4	63.6
	Sometimes	22.9	27.7	22.4	21.5	23.2
	Rarely	8.5	4.7	8.1	10.6	8.9
	Never	2.9	2.7	1.1	5.5	3.8
	Not applicable / don't know	0.9	3.2	0.7	0.5	0.6
	Prefer not to say	0.3	0.0	0.5	0.5	0.0
I feel full of energy these days	Often	10.8	21.8	13.6	6.3	6.5
	Sometimes	33.1	38.6	38.9	28.1	26.2
	Rarely	30.3	28.5	27.6	32.7	33.2
	Never	25.2	9.8	19.9	31.9	33.1
	Not applicable / don't know	0.6	1.3	0.0	1.0	0.9
	Prefer not to say	0.0	0.0	0.0	0.0	0.0
I feel that life is full of opportunities	Often	26.8	38.9	31.2	22.8	19.5
	Sometimes	31.3	30.1	35.8	26.5	28.0
	Rarely	23.6	18.9	18.1	26.3	31.6
	Never	16.1	8.9	13.1	21.2	19.4
	Not applicable / don't know	1.9	3.2	1.5	2.6	1.6
	Prefer not to say	0.3	0.0	0.3	0.6	0.0
I feel that the future looks good for me	Often	34.9	45.9	39.4	28.6	28.9
	Sometimes	31.1	35.8	33.2	29.2	27.9

CASP-12 Item	Response	HCP1-4 (%)	HCP1 (%)	HCP2 (%)	HCP3 (%)	HCP4 (%)
	Rarely	19.6	8.6	17.0	22.9	24.6
	Never	11.2	8.1	7.8	16.3	13.9
	Not applicable / don't know	2.6	1.0	2.2	2.2	3.8
	Prefer not to say	0.6	0.6	0.4	0.5	0.9

Table 45: ASCOT SCT-4 responses – HCP clients

Domains / Responses	HCP1-4 (%)	HCP1 (%)	HCP2 (%)	HCP3 (%)	HCP4 (%)
Control over daily life					
I have as much control over my daily life as I want	35.7	41.9	37.4	34.2	32.2
I have adequate control over my daily life	38.7	41.1	40.2	34.8	38.4
I have some control over my daily life, but not enough	21.0	14.8	19.1	26.2	22.3
I have no control over my daily life	3.9	1.5	2.9	4.3	5.7
Not applicable / don't know	0.7	0.6	0.3	0.5	1.4
Prefer not to say	0.0	0.0	0.0	0.0	0.0
Personal cleanliness and comfort					
I feel clean and am able to present myself the way I like	62.6	75.9	62.2	58.1	62.4
I feel adequately clean and presentable	34.1	21.3	34.3	37.7	34.9
I feel less than adequately clean or presentable	2.2	2.2	2.7	1.7	1.7
I don't feel at all clean or presentable	0.8	0.0	0.7	1.9	0.5
Not applicable / don't know	0.3	0.6	0.0	0.5	0.5
Prefer not to say	0.0	0.0	0.0	0.0	0.0
Food and drink					
I get all the food and drink I like when I want	70.4	66.6	67.7	71.7	74.7
I get adequate food and drink at OK times	24.9	28.4	26.6	23.1	22.4
I don't always get adequate or timely food and drink	3.1	2.8	4.0	3.6	1.4
I don't always get adequate or timely food and drink, and I think there is a risk to my health	0.8	0.9	1.3	1.0	0.0
Not applicable / don't know	0.6	1.4	0.0	0.5	1.5
Prefer not to say	0.2	0.0	0.4	0.0	0.0
Personal safety					
I feel as safe as I want	44.9	55.5	44.5	39.1	46.2
Generally I feel adequately safe, but not as safe as I would like	46.2	39.7	47.1	50.9	43.6
I feel less than adequately safe	6.5	2.9	6.9	5.9	7.3
I don't feel at all safe	1.7	1.3	1.1	3.5	1.5
Not applicable / don't know	0.6	0.6	0.4	0.5	0.9

Domains / Responses	HCP1-4 (%)	HCP1 (%)	HCP2 (%)	HCP3 (%)	HCP4 (%)
Prefer not to say	0.1	0.0	0.0	0.0	0.5
Social participation and involvement					
I have as much social contact as I want with people I like	37.3	46.8	39.5	31.4	35.2
I have adequate social contact with people	35.9	33.2	36.7	30.0	39.5
I have some social contact with people, but not enough	17.9	15.0	15.3	25.0	17.7
I have little social contact with people and feel socially isolated	8.4	4.3	8.1	12.6	7.2
Not applicable / don't know	0.6	0.6	0.4	1.1	0.5
Prefer not to say	0.0	0.0	0.0	0.0	0.0
Occupation					
I'm able to spend my time as I want, doing things I value or enjoy	28.4	36.1	29.6	26.0	26.0
I'm able to do enough of the things I value or enjoy with my time	35.1	36.4	38.7	31.3	31.7
I do some of the things I value or enjoy with my time, but not enough	29.1	22.7	28.3	29.2	32.3
I don't do anything I value or enjoy with my time	6.1	3.5	2.9	10.8	8.5
Not applicable / don't know	1.1	1.0	0.4	2.1	1.5
Prefer not to say	0.1	0.3	0.0	0.5	0.0
Accommodation cleanliness and comfort					
My home is as clean and comfortable as I want	72.9	68.8	76.3	70.0	70.9
My home is adequately clean and comfortable	23.4	26.0	20.6	25.4	25.5
My home is not quite clean or comfortable enough	3.2	3.9	3.1	3.9	2.6
My home is not at all clean or comfortable	0.2	0.0	0.0	0.2	0.5
Not applicable / don't know	0.3	0.6	0.0	0.5	0.5
Prefer not to say	0.1	0.6	0.0	0.0	0.0
Dignity (having help)					
Having help makes me think and feel better about myself	55.8	54.4	56.7	55.1	55.4
Having help does not affect the way I think or feel about myself	29.9	35.0	32.0	24.7	28.8
Having help sometimes undermines the way I think and feel about myself	11.7	8.6	8.9	15.7	14.1
Having help completely undermines the way I think and feel about myself	1.0	0.6	0.4	3.0	0.8
Not applicable / don't know	1.4	1.4	1.6	1.7	1.0
Prefer not to say	0.2	0.0	0.5	0.0	0.0
Dignity (the way help is provided)					
The way I'm helped and treated makes me think and feel better about myself	60.5	51.3	62.5	55.6	63.5
The way I'm helped and treated does not affect the way I think or feel about myself	29.8	39.8	30.3	29.6	26.5

Domains / Responses	HCP1-4 (%)	HCP1 (%)	HCP2 (%)	HCP3 (%)	HCP4 (%)
The way I'm helped and treated sometimes undermines the way I think and feel about myself	7.8	7.0	5.7	11.9	8.3
The way I'm helped and treated completely undermines the way I think and feel about myself	0.5	0.0	0.7	0.6	0.2
Not applicable / don't know	1.4	2.0	0.8	2.3	1.5
Prefer not to say	0.0	0.0	0.0	0.0	0.0

Table 46: Main concerns, complaints and resolutions – HCP clients

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 (%)
Case management	27.3	3.2	72.7	3.7	55.6	3.8	3.2
Service coordination/rostering	20.6	4.8	79.4	8.2	48.3	8.4	9.0
Inadequate correspondence or information	21.8	2.1	78.2	3.2	56.9	4.5	2.8
Services not tailored to my needs	30.6	1.7	69.4	1.7	57.9	2.6	1.8
Value for money (e.g. fees too high)	47.1	12.6	52.9	6.2	51.5	6.5	6.3
Transparency around fees & charges	30.5	4.6	69.5	4.6	41.0	3.8	5.2
Monthly statements/invoicing	26.9	4.7	73.1	5.7	45.1	6.5	7.7
Waiting time for funds/services/reimbursements	27.3	3.6	72.7	4.2	48.0	3.9	4.2
Respite	0.0	0.0	100.0	0.4	100.0	1.2	0.0
Domestic assistance/cleaning	20.9	2.1	79.1	3.6	42.8	3.0	4.2
Meal preparation	22.4	0.5	77.6	0.8	68.1	0.8	0.4
Transport	27.0	1.2	73.0	1.4	40.5	1.1	1.7
Social support/activities that are enjoyable	65.2	2.3	34.8	0.5	100.0	0.4	0.0
Accessing personal care services	59.5	0.5	40.5	0.2	100.0	0.4	0.0
Accessing nursing services	100.0	0.2	0.0	0.0	0.0	0.0	0.0
Accessing other health professionals (e.g. allied health)	38.2	1.1	61.8	0.8	67.1	0.9	0.0
Showering, grooming or dressing	45.4	0.7	54.6	0.4	38.5	0.4	0.6
Assistance with toileting	0.0	0.0	100.0	0.1	100.0	0.3	0.0
Mobility and falls prevention	20.6	0.6	79.4	1.1	60.2	1.2	0.8
Medical (e.g. continence, wounds, pain)	20.5	0.6	79.5	1.0	0.0	0.0	0.8
Medication management	30.2	1.1	69.8	1.1	35.0	0.5	0.9

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 (%)
Goods, equipment & assistive technology	9.6	0.2	90.4	1.0	46.3	0.9	0.7
Home maintenance (keeping the home & garden safe)	41.1	2.5	58.9	1.6	56.5	1.3	1.0
Home modifications (changes to improve safety & access)	31.8	1.5	68.2	1.4	54.3	0.9	0.8
Staff attitude, body language or conduct, like staff being unkind, rude, or unhappy	0.0	0.0	100.0	1.3	24.8	0.8	2.4
Continuity of staff	24.7	5.1	75.3	6.8	36.1	5.5	10.1
Staff not being adequately trained	24.9	4.3	75.1	5.7	29.8	3.1	7.1
Poor communication between staff	29.0	1.9	71.0	2.0	41.8	1.3	1.9
Staff badge/role not displayed	52.6	0.8	47.4	0.3	56.9	0.5	0.4
Staff not being culturally sensitive (caring about my beliefs, values, spirituality, customs or religion)	0.0	0.0	100.0	0.3	0.0	0.0	0.8
Being hurt or treated roughly by staff	0.0	0.0	100.0	0.1	0.0	0.0	0.0
Use of restraint	0.0	0.0	100.0	0.2	0.0	0.0	0.5
Staff not on time/cancel regularly	16.9	1.3	83.1	2.9	37.7	1.8	3.0
Staff being mismatched (e.g. not preferred gender)	14.9	0.7	85.1	1.8	0.0	0.0	3.6
Not being allowed to do certain things	56.5	1.1	43.5	0.4	100.0	0.7	0.0
Being treated like a child	59.9	1.2	40.1	0.4	100.0	0.1	0.0
Continence pads (e.g. forced use, insufficient supply or changing)	45.9	0.5	54.1	0.3	54.8	0.2	0.1
Shouted at by staff	100.0	0.3	0.0	0.0	0.0	0.0	0.0
Needs and wishes not considered	29.3	0.7	70.7	0.8	85.5	1.0	0.2
No individualised care plan	53.4	0.6	46.6	0.2	0.0	0.0	0.4
Independence not supported e.g. not able to leave the house	16.1	0.2	83.9	0.5	68.9	0.7	0.3

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 (%)
Lack of choices about social interaction	19.8	0.4	80.2	0.7	64.3	1.2	0.7
Lack of activities to choose from	67.1	3.8	32.9	0.8	50.2	0.9	0.6
Not included in planning/decision making	70.1	1.7	29.9	0.3	100.0	0.6	0.0
Not able to choose required services	37.3	0.7	62.7	0.5	77.4	0.9	0.3
Not able to choose when and how services are provided	23.1	0.8	76.9	1.2	78.3	2.3	0.7
Not able to choose who provides services	27.2	1.6	72.8	1.9	42.2	2.1	3.0
Not able to negotiate costs	39.2	1.9	60.8	1.3	65.6	1.7	0.9
Lack of clarity about what I am entitled to	43.8	6.4	56.2	3.6	59.0	4.0	2.9
Any other concerns about finances and administration	30.5	3.9	69.5	3.9	75.2	7.0	2.0
Any other concerns about services	30.3	2.4	69.7	2.4	76.6	2.9	0.9
Any other concerns about personal or medical care	39.3	1.8	60.7	1.2	81.7	1.7	0.4
Any other concerns about equipment, home maintenance or home modification	23.2	1.1	76.8	1.7	84.6	2.6	0.5
Any other concerns about home care staff	15.3	1.0	82.8	2.4	30.7	1.6	3.5
Any other concerns about being treated with dignity and respect	0.0	0.0	100.0	0.6	68.3	0.8	0.4
Any other concerns about being given enough choice	49.4	1.1	50.6	0.5	61.6	0.9	0.5

* 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 47: Most common reasons why HCP clients did not discuss or report their main concerns

Main concerns	Share of all main concerns not discussed or reported (%)	Share of main concerns not discussed or reported because clients thought nothing would change (%)	Share of main concerns not discussed or reported because clients thought they were too minor (%)	Share of main concerns not discussed or reported because clients did not want to be a nuisance (%)
Value for money (e.g. fees too high)	12.6	30.7	13.3	19.3
Lack of clarity about what I am entitled to	6.4	4.2	3.5	2.0
Continuity of staff	5.1	1.4	5.3	3.0
Service coordination/rostering	4.8	4.0	8.5	11.4
Monthly statements/invoicing	4.7	3.4	9.8	2.8
Transparency around fees & charges	4.6	16.3	0.0	1.4
Staff not being adequately trained	4.3	0.7	9.2	9.2
Any other concerns about finances and administration	3.9	2.1	1.5	0.0
Lack of activities to choose from	3.8	3.9	2.2	4.7
Waiting time for funds/services/reimbursements	3.6	4.7	7.6	4.9
Case management	3.2	4.2	4.3	1.9
Home maintenance (keeping the home & garden safe)	2.5	1.7	0.0	7.6
Any other concerns about services	2.4	2.2	0.0	3.3
Social support/activities that are enjoyable	2.3	2.9	1.7	1.9
Domestic assistance/cleaning	2.1	0.0	0.0	5.9
Inadequate correspondence or information	2.1	2.1	3.1	5.6
Not able to negotiate costs	1.9	1.7	0.0	0.0
Poor communication between staff	1.9	0.0	2.7	0.0
Any other concerns about personal or medical care	1.8	0.0	0.0	0.0
Services not tailored to client's needs	1.7	1.5	3.0	2.6

Main concerns	Share of all main concerns not discussed or reported (%)	Share of main concerns not discussed or reported because clients thought nothing would change (%)	Share of main concerns not discussed or reported because clients thought they were too minor (%)	Share of main concerns not discussed or reported because clients did not want to be a nuisance (%)
Not included in planning/decision making	1.7	0.0	0.8	0.0
Not able to choose who provides services	1.6	0.0	0.0	0.0
Home modifications (changes to improve safety & access)	1.5	3.8	2.7	2.3
Staff not on time/cancel regularly	1.3	0.0	1.8	0.0
Being treated like a child	1.2	0.0	0.0	2.1
Transport	1.2	3.3	0.9	1.0
Any other concerns about equipment, home maintenance or home modification	1.1	0.0	0.0	0.0
Accessing other health professionals (e.g. allied health)	1.1	0.0	1.7	1.9
Not being allowed to do certain things	1.1	0.0	0.0	0.0
Any other concerns about being given enough choice	1.1	0.0	0.0	0.0
Medication management	1.1	0.0	0.0	0.0
Any other concerns about home care staff	1.0	0.0	0.0	2.2
Not able to choose when and how services are provided	0.8	2.8	1.7	0.5
Staff badge/role not displayed	0.8	0.0	2.9	0.3
Needs and wishes not considered	0.7	0.0	2.7	0.0
Staff being mismatched (e.g. not preferred gender)	0.7	0.0	3.4	0.0
Not able to choose required services	0.7	0.0	0.2	0.0
Showering, grooming or dressing	0.7	0.0	0.0	0.0
Mobility and falls prevention	0.6	0.0	0.0	0.0

Main concerns	Share of all main concerns not discussed or reported (%)	Share of main concerns not discussed or reported because clients thought nothing would change (%)	Share of main concerns not discussed or reported because clients thought they were too minor (%)	Share of main concerns not discussed or reported because clients did not want to be a nuisance (%)
No individualised care plan	0.6	0.0	0.0	0.0
Medical (e.g. continence, wounds, pain)	0.6	0.0	0.0	0.0
Accessing personal care services	0.5	0.0	0.0	0.0
Meal preparation	0.5	1.4	1.9	2.2
Continence pads (e.g. forced use, insufficient supply or changing)	0.5	0.0	0.0	0.0
Lack of choices about social interaction	0.4	1.0	1.7	0.0
Shouted at by staff	0.3	0.0	0.0	0.0
Accessing nursing services	0.2	0.0	1.8	0.0
Goods, equipment & assistive technology	0.2	0.0	0.0	0.0
Independence not supported e.g. not able to leave the house	0.2	0.0	0.0	0.0
Respite	0.0	0.0	0.0	0.0
Assistance with toileting	0.0	0.0	0.0	0.0
Staff attitude, body language or conduct, like staff being unkind, rude, or unhappy	0.0	0.0	0.0	0.0
Staff not being culturally sensitive (caring about my beliefs, values, spirituality, customs or religion)	0.0	0.0	0.0	0.0
Being hurt or treated roughly by staff	0.0	0.0	0.0	0.0
Use of restraint	0.0	0.0	0.0	0.0
Any other concerns about being treated with dignity and respect	0.0	0.0	0.0	0.0

9.2.2 CHSP respite clients

Table 48: Quality of care – CHSP respite clients

	Never	Rarely	Sometimes	Mostly	Always	Don't know	Prefer not to say
Treated with respect and dignity	0.5%	0.6%	2.5%	20.5%	75.9%	0.5%	0.0%
Supported to make my own decisions about the care and services I receive	8.6%	1.1%	13.8%	29.6%	43.6%	2.6%	0.7%
Receive care and support from aged care staff who have the appropriate skills and training	4.1%	2.1%	8.3%	30.1%	55.3%	0.0%	0.0%
Receive services and support for daily living that are important for my health and wellbeing	2.0%	3.4%	8.4%	30.0%	54.7%	1.6%	0.0%
Supported to maintain my social relationships and connections with the community	6.3%	6.1%	18.1%	28.8%	37.6%	3.1%	0.0%
Know how to lodge a complaint	46.0%	6.0%	7.8%	8.8%	27.8%	2.9%	0.7%
Comfortable lodging complaints	26.1%	11.3%	12.2%	16.6%	28.4%	4.7%	0.7%
Confident that appropriate action will be taken when I make a complaint	11.4%	4.3%	12.4%	27.1%	34.2%	9.2%	1.4%

Table 49: CASP-12 responses – CHSP respite

CASP-12 Item	Response	%
My age prevents me from doing the things I would like to	Often	50.7
	Sometimes	25.6
	Rarely	5.7
	Never	11.5
	Not applicable / don't know	6.5
	Prefer not to say	0.0
I feel that what happens to me is out of my control	Often	33.5
	Sometimes	40.5
	Rarely	10.2
	Never	11.8
	Not applicable / don't know	3.9
	Prefer not to say	0.0
I feel left out of things	Often	20.3
	Sometimes	39.1
	Rarely	13.7
	Never	21.7
	Not applicable / don't know	4.8
	Prefer not to say	0.4
I can do the things that I want to do	Often	24.6
	Sometimes	33.3
	Rarely	22.9
	Never	15.4
	Not applicable / don't know	3.8
	Prefer not to say	0.0
Family responsibilities prevent me from doing what I want to do	Often	15.3
	Sometimes	16.3
	Rarely	14.2
	Never	49.5
	Not applicable / don't know	4.6
	Prefer not to say	0.0
Shortage of money stops me from doing the things I want to do	Often	15.8
	Sometimes	17.6
	Rarely	16.7
	Never	46.2
	Not applicable / don't know	3.7
	Prefer not to say	0.0
I look forward to each day	Often	44.5
	Sometimes	30.0
	Rarely	14.3

CASP-12 Item	Response	%
	Never	6.0
	Not applicable / don't know	5.2
	Prefer not to say	0.0
I feel that my life has meaning	Often	37.3
	Sometimes	27.2
	Rarely	19.8
	Never	7.5
	Not applicable / don't know	7.7
	Prefer not to say	0.5
On balance, I look back on my life with a sense of happiness	Often	58.7
	Sometimes	28.0
	Rarely	8.6
	Never	1.5
	Not applicable / don't know	3.2
	Prefer not to say	0.0
I feel full of energy these days	Often	11.3
	Sometimes	31.8
	Rarely	31.7
	Never	22.8
	Not applicable / don't know	2.4
	Prefer not to say	0.0
I feel that life is full of opportunities	Often	18.2
	Sometimes	26.1
	Rarely	23.7
	Never	23.4
	Not applicable / don't know	8.1
	Prefer not to say	0.5
I feel that the future looks good for me	Often	20.4
	Sometimes	24.3
	Rarely	23.8
	Never	24.3
	Not applicable / don't know	7.2
	Prefer not to say	0.0

Table 50: ASCOT SCT-4 responses – CHSP respite clients

Domains / Responses	(%)
Control over daily life	
I have as much control over my daily life as I want	16.1
I have adequate control over my daily life	38.3
I have some control over my daily life, but not enough	32.9
I have no control over my daily life	11.1
Not applicable / don't know	1.6
Prefer not to say	0.0
Personal cleanliness and comfort	
I feel clean and am able to present myself the way I like	46.9
I feel adequately clean and presentable	49.0
I feel less than adequately clean or presentable	1.2
I don't feel at all clean or presentable	0.0
Not applicable / don't know	2.3
Prefer not to say	0.7
Food and drink	
I get all the food and drink I like when I want	59.1
I get adequate food and drink at OK times	33.4
I don't always get adequate or timely food and drink	5.1
I don't always get adequate or timely food and drink, and I think there is a risk to my health	0.7
Not applicable / don't know	1.8
Prefer not to say	0.0
Personal safety	
I feel as safe as I want	36.3
Generally I feel adequately safe, but not as safe as I would like	51.9
I feel less than adequately safe	8.1
I don't feel at all safe	1.4
Not applicable / don't know	2.3
Prefer not to say	0.0
Social participation and involvement	
I have as much social contact as I want with people I like	21.5
I have adequate social contact with people	35.2
I have some social contact with people, but not enough	35.5
I have little social contact with people and feel socially isolated	5.3
Not applicable / don't know	2.6
Prefer not to say	0.0
Occupation	
I'm able to spend my time as I want, doing things I value or enjoy	17.4
I'm able to do enough of the things I value or enjoy with my time	29.3
I do some of the things I value or enjoy with my time, but not enough	42.9
I don't do anything I value or enjoy with my time	6.4
Not applicable / don't know	4.1
Prefer not to say	0.0
Accommodation cleanliness and comfort	
My home is as clean and comfortable as I want	72.8
My home is adequately clean and comfortable	24.1
My home is not quite clean or comfortable enough	2.1
My home is not at all clean or comfortable	0.0

Domains / Responses	(%)
Not applicable / don't know	0.9
Prefer not to say	0.0
Dignity (<i>having</i> help)	
Having help makes me think and feel better about myself	44.9
Having help does not affect the way I think or feel about myself	34.1
Having help sometimes undermines the way I think and feel about myself	13.5
Having help completely undermines the way I think and feel about myself	0.7
Not applicable / don't know	6.7
Prefer not to say	0.0
Dignity (the <i>way</i> help is provided)	
The way I'm helped and treated makes me think and feel better about myself	49.6
The way I'm helped and treated does not affect the way I think or feel about myself	33.9
The way I'm helped and treated sometimes undermines the way I think and feel about myself	11.7
The way I'm helped and treated completely undermines the way I think and feel about myself	0.2
Not applicable / don't know	4.7
Prefer not to say	0.0

Table 51: Main concerns, complaints and resolutions – CHSP respite clients

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 (%)
Lack of clarity about what I am entitled to	52.8	10.2	41.4	5.7	41.7	4.6	11.0
Inadequate correspondence or information	44.9	4.7	55.1	4.1	53.1	4.5	6.7
Services not tailored to my needs	43.6	2.6	56.4	2.4	66.7	4.1	3.5
Value for money (e.g. fees too high)	38.1	8.4	61.9	9.7	50.7	8.7	14.4
Transparency around fees & charges	47.4	8.2	52.6	6.5	100.0	8.6	0.0
Meal preparation	62.0	4.2	38.0	1.8	50.0	2.1	3.5
Activities that are enjoyable	0.0	0.0	100.0	4.1	100.0	4.1	0.0
Being connected with the community	67.3	1.3	32.7	0.5	0.0	0.0	2.0
Transport	72.8	2.8	27.2	0.7	0.0	0.0	0.0
Loneliness and boredom	49.3	6.5	50.7	4.7	33.3	2.1	7.0
Staff attitude, body language or conduct, like staff being unkind, rude, or unhappy	28.7	2.2	71.3	3.8	100.0	5.9	0.0
Continuity of staff	37.1	4.5	62.9	5.4	100.0	7.9	0.0
Staff not being adequately trained	61.1	8.0	38.9	3.6	52.8	4.0	6.0
Poor communication between staff	56.2	2.3	43.8	1.3	0.0	0.0	2.0
Staff badge/role not displayed	100.0	3.5	0.0	0.0	0.0	0.0	0.0
Staff not on time/cancel regularly	32.4	3.2	67.6	4.8	44.3	1.9	4.0
Staff being mismatched to my preferences (e.g. not preferred gender)	15.7	1.0	84.3	3.8	0.0	0.0	13.0
Being treated like a child	57.1	1.0	42.9	0.6	0.0	0.0	0.0
Continence pads (e.g. forced use, insufficient supply or changing)	0.0	0.0	100.0	3.2	34.2	2.1	6.7
Being shouted at by staff	100.0	1.1	0.0	0.0	0.0	0.0	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 (%)
Needs and wishes not considered	0.0	0.0	100.0	0.8	100.0	2.1	0.0
Independence not supported e.g. not able to leave the house	0.0	0.0	100.0	0.6	0.0	0.0	0.0
Lack of activities to choose from	70.3	3.4	29.7	1.0	100.0	0.6	0.0
Not included in planning/decision making	53.6	1.1	46.4	0.7	0.0	0.0	0.0
Not able to choose required services	100.0	0.8	0.0	0.0	0.0	0.0	0.0
Not able to choose when and how services are provided	21.4	1.0	78.6	2.7	100.0	3.5	0.0
Not able to choose who provides services	47.8	1.9	52.2	1.5	100.0	2.4	0.0
Showering, grooming or dressing	0.0	0.0	100.0	0.9	0.0	0.0	0.0
Mobility and falls prevention	0.0	0.0	100.0	0.8	100.0	2.1	0.0
Medical (e.g. continence, wounds, pain)	0.0	0.0	100.0	1.3	0.0	0.0	0.0
Feeling safe in the respite facility	0.0	0.0	100.0	1.6	100.0	4.1	0.0
Cleanliness and maintenance of the respite facility	40.3	1.1	59.7	1.2	100.0	1.9	0.0
Any other concerns about home care staff	56.2	2.3	43.8	1.3	0.0	0.0	2.0
Any other concerns about being treated with dignity and respect	44.8	0.6	55.2	0.6	100.0	1.4	0.0
Any other concerns about finances and administration	25.3	3.6	74.7	7.5	43.7	6.3	11.4
Any other concerns about services	30.7	3.3	69.3	5.4	60.0	6.2	7.0
Any other concerns about being given enough choice	23.0	1.8	77.0	4.2	100.0	7.0	0.0
Any other concerns about medical and health care	57.1	1.0	42.9	0.6	0.0	0.0	0.0
Any other concerns about the respite facility	66.0	2.2	34.0	0.8	100.0	2.1	0.0

* Main concerns unreported, 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 52: Most common reasons why CHSP respite clients did not discuss or report their main concerns

Main concerns	Share of all main concerns not discussed or reported (%)	Share of main concerns not discussed or reported because it was not worth complaining (%)	Share of main concerns not discussed or reported because clients did not have the capacity to complain (%)	Share of main concerns not discussed or reported because clients did not want to be a nuisance (%)
Lack of clarity about what I am entitled to	10.2	4.7	7.1	0.0
Value for money (e.g. fees too high)	8.4	10.7	4.3	0.0
Transparency around fees & charges	8.2	8.3	6.1	0.0
Staff not being adequately trained	8.0	6.4	19.4	12.7
Loneliness and boredom	6.5	4.3	7.1	12.7
Inadequate correspondence or information	4.7	6.5	12.3	0.0
Continuity of staff	4.5	4.7	11.5	11.8
Meal preparation	4.2	5.8	4.3	0.0
Any other concerns about finances and administration	3.6	5.0	6.1	0.0
Staff badge/role not displayed	3.5	3.0	5.7	0.0
Lack of activities to choose from	3.4	3.1	0.0	0.0
Any other concerns about services	3.3	4.6	0.0	0.0
Staff not on time/cancel regularly	3.2	1.5	5.8	12.7
Transport	2.8	3.9	0.0	0.0
Services not tailored to my needs	2.6	1.4	0.0	12.7
Poor communication between staff	2.3	1.6	0.0	12.7
Any other concerns about home care staff	2.3	3.1	0.0	0.0
Any other concerns about the respite facility	2.2	3.0	0.0	0.0
Staff attitude, body language or conduct, like staff being unkind, rude, or unhappy	2.2	3.0	0.0	0.0
Not able to choose who provides services	1.9	2.7	4.3	0.0
Any other concerns about being given enough choice	1.8	2.4	6.1	0.0

Main concerns	Share of all main concerns not discussed or reported (%)	Share of main concerns not discussed or reported because it was not worth complaining (%)	Share of main concerns not discussed or reported because clients did not have the capacity to complain (%)	Share of main concerns not discussed or reported because clients did not want to be a nuisance (%)
Being connected with the community	1.3	1.8	0.0	0.0
Being shouted at by staff	1.1	1.6	0.0	0.0
Not included in planning/decision making	1.1	0.0	0.0	12.7
Cleanliness and maintenance of the respite facility	1.1	1.6	0.0	0.0
Being treated like a child	1.0	1.4	0.0	0.0
Not able to choose when and how services are provided	1.0	0.0	0.0	11.8
Any other concerns about medical and health care	1.0	1.4	0.0	0.0
Staff being mismatched to my preferences (e.g. not preferred gender)	1.0	1.4	0.0	0.0
Not able to choose required services	0.8	0.0	0.0	0.0
Any other concerns about being treated with dignity and respect	0.6	0.9	0.0	0.0
Activities that are enjoyable	0.0	0.0	0.0	0.0
Continence pads (e.g. forced use, insufficient supply or changing)	0.0	0.0	0.0	0.0
Needs and wishes not considered	0.0	0.0	0.0	0.0
Independence not supported e.g. not able to leave the house	0.0	0.0	0.0	0.0
Showering, grooming or dressing	0.0	0.0	0.0	0.0
Mobility and falls prevention	0.0	0.0	0.0	0.0
Medical (e.g. continence, wounds, pain)	0.0	0.0	0.0	0.0
Feeling safe in the respite facility	0.0	0.0	0.0	0.0

9.2.3 Residential respite clients

Table 53: Quality of care – residential respite clients

	Never	Rarely	Sometimes	Mostly	Always	Don't know	Prefer not to say
Treated with respect and dignity	0.5%	0.5%	8.0%	18.1%	72.3%	0.5%	0.0%
Supported to make my own decisions about the care and services I receive	2.7%	6.9%	15.4%	25.9%	42.6%	5.9%	0.5%
Receive care and support from aged care staff who have the appropriate skills and training	0.0%	2.6%	10.1%	24.7%	61.6%	1.0%	0.0%
Receive services and support for daily living that are important for my health and wellbeing	0.0%	4.3%	6.7%	27.6%	57.6%	2.9%	0.8%
Supported to maintain my social relationships and connections with the community	6.3%	7.5%	13.5%	21.6%	43.7%	6.4%	1.1%
Know how to lodge a complaint	30.4%	12.5%	9.6%	13.7%	30.1%	2.7%	0.8%
Comfortable lodging complaints	18.1%	10.9%	14.7%	15.7%	32.7%	7.4%	0.5%
Confident that appropriate action will be taken when I make a complaint	9.7%	6.2%	13.6%	23.8%	35.4%	10.3%	1.0%

Table 54: CASP-12 responses – residential respite clients

CASP-12 Item	Response	%
My age prevents me from doing the things I would like to	Often	46.7
	Sometimes	30.2
	Rarely	8.4
	Never	14.1
	Not applicable / don't know	0.6
	Prefer not to say	0.0
I feel that what happens to me is out of my control	Often	28.3
	Sometimes	32.9
	Rarely	14.0
	Never	19.0
	Not applicable / don't know	5.7
	Prefer not to say	0.0
I feel left out of things	Often	13.0
	Sometimes	31.2
	Rarely	17.6
	Never	34.5
	Not applicable / don't know	3.7
	Prefer not to say	0.0
I can do the things that I want to do	Often	32.9
	Sometimes	33.0
	Rarely	18.0
	Never	14.0
	Not applicable / don't know	2.1
	Prefer not to say	0.0
Family responsibilities prevent me from doing what I want to do	Often	7.5
	Sometimes	11.8
	Rarely	16.8
	Never	60.1
	Not applicable / don't know	3.9
	Prefer not to say	0.0
Shortage of money stops me from doing the things I want to do	Often	5.1
	Sometimes	14.3
	Rarely	16.8
	Never	58.5
	Not applicable / don't know	4.7
	Prefer not to say	0.6
I look forward to each day	Often	54.8
	Sometimes	21.1
	Rarely	11.2

CASP-12 Item	Response	%
	Never	7.0
	Not applicable / don't know	5.8
	Prefer not to say	0.0
I feel that my life has meaning	Often	40.7
	Sometimes	31.6
	Rarely	13.8
	Never	6.1
	Not applicable / don't know	7.9
	Prefer not to say	0.0
On balance, I look back on my life with a sense of happiness	Often	63.1
	Sometimes	23.1
	Rarely	3.6
	Never	3.6
	Not applicable / don't know	6.7
	Prefer not to say	0.0
I feel full of energy these days	Often	8.9
	Sometimes	33.5
	Rarely	28.2
	Never	26.7
	Not applicable / don't know	2.7
	Prefer not to say	0.0
I feel that life is full of opportunities	Often	23.5
	Sometimes	22.8
	Rarely	21.8
	Never	22.6
	Not applicable / don't know	9.3
	Prefer not to say	0.0
I feel that the future looks good for me	Often	27.0
	Sometimes	32.0
	Rarely	17.9
	Never	15.4
	Not applicable / don't know	7.0
	Prefer not to say	0.6

Table 55: ASCOT SCT-4 responses – residential respite clients

Domains / Responses	(%)
Control over daily life	
I have as much control over my daily life as I want	26.7
I have adequate control over my daily life	33.7
I have some control over my daily life, but not enough	30.3
I have no control over my daily life	7.7
Not applicable / don't know	1.5
Prefer not to say	0.0
Personal cleanliness and comfort	
I feel clean and am able to present myself the way I like	56.7
I feel adequately clean and presentable	38.3
I feel less than adequately clean or presentable	1.9
I don't feel at all clean or presentable	0.0
Not applicable / don't know	3.1
Prefer not to say	0.0
Food and drink	
I get all the food and drink I like when I want	59.8
I get adequate food and drink at OK times	34.3
I don't always get adequate or timely food and drink	3.0
I don't always get adequate or timely food and drink, and I think there is a risk to my health	1.2
Not applicable / don't know	1.2
Prefer not to say	0.6
Personal safety	
I feel as safe as I want	57.8
Generally I feel adequately safe, but not as safe as I would like	34.2
I feel less than adequately safe	4.6
I don't feel at all safe	0.6
Not applicable / don't know	2.7
Prefer not to say	0.0
Social participation and involvement	
I have as much social contact as I want with people I like	34.1
I have adequate social contact with people	34.6
I have some social contact with people, but not enough	18.7
I have little social contact with people and feel socially isolated	9.8
Not applicable / don't know	2.4
Prefer not to say	0.6
Occupation	
I'm able to spend my time as I want, doing things I value or enjoy	29.2
I'm able to do enough of the things I value or enjoy with my time	28.2
I do some of the things I value or enjoy with my time, but not enough	28.5
I don't do anything I value or enjoy with my time	10.0
Not applicable / don't know	4.2
Prefer not to say	0.0
Accommodation cleanliness and comfort	
My home is as clean and comfortable as I want	72.6
My home is adequately clean and comfortable	25.0
My home is not quite clean or comfortable enough	1.8
My home is not at all clean or comfortable	0.0

Not applicable / don't know	0.6
Prefer not to say	0.0
Dignity (<i>having</i> help)	
Having help makes me think and feel better about myself	50.5
Having help does not affect the way I think or feel about myself	26.5
Having help sometimes undermines the way I think and feel about myself	15.3
Having help completely undermines the way I think and feel about myself	3.3
Not applicable / don't know	3.1
Prefer not to say	1.2
Dignity (the <i>way</i> help is provided)	
The way I'm helped and treated makes me think and feel better about myself	53.9
The way I'm helped and treated does not affect the way I think or feel about myself	29.3
The way I'm helped and treated sometimes undermines the way I think and feel about myself	13.1
The way I'm helped and treated completely undermines the way I think and feel about myself	0.0
Not applicable / don't know	3.1
Prefer not to say	0.6

Table 56: Main concerns, complaints and resolutions – residential respite clients

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 (%)
Not being allowed to do certain things	100.0	1.5	0.0	0.0	0.0	0.0	2.0
Being treated like a child	71.5	4.7	28.5	1.3	50.0	2.7	2.0
Continence pads (e.g. forced use, insufficient supply or changing)	50.0	0.9	50.0	0.6	100.0	0.0	0.0
Being shouted at by staff	100.0	0.9	0.0	0.0	0.0	0.0	0.0
Not being informed of daily routine	33.7	0.9	66.3	1.3	0.0	0.0	0.0
Choices about how and when to interact with other residents	78.1	3.4	21.9	0.6	0.0	2.8	0.0
Choices about personal care, like choosing when to shower	75.0	2.8	25.0	0.6	0.0	0.0	2.0
Choices around the timing of meals	50.0	0.9	50.0	0.6	100.0	0.0	3.9
Having enough lifestyle activities to choose from	44.5	3.8	55.5	3.2	50.2	5.4	0.0
How I am helped to shower	0.0	0.0	100.0	0.6	0.0	2.7	0.0
How I am helped with eating	0.0	0.0	100.0	0.6	0.0	0.0	0.0
How I am helped to use to the toilet	0.0	0.0	100.0	0.6	0.0	2.7	0.0
How I am helped to get around	100.0	0.9	0.0	0.0	0.0	0.0	1.2
How I am helped with personal grooming, like cutting nails or shaving	83.0	2.8	17.0	0.4	100.0	0.0	2.0
How I am helped with continence aids	50.0	1.9	50.0	1.3	50.0	2.7	0.0
Seeing a GP when needed	38.4	0.9	61.6	1.0	0.0	0.0	7.1
Accessing allied health services (e.g. physio, podiatry etc.)	31.8	2.5	68.2	3.6	78.4	0.0	3.2
The way client's medication is managed	18.4	3.8	81.6	11.4	16.9	21.8	0.0
How any wounds have been looked after	0.0	0.0	100.0	1.0	0.0	0.0	0.0
How catheters are used	0.0	0.0	100.0	0.6	0.0	2.7	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 pain is managed	23.3	0.6	76.7	1.3	0.0	0.0	0.0
Falls or fall prevention	33.2	0.9	66.8	1.3	0.0	2.7	0.0
The overall appearance of the facility	50.4	0.9	49.6	0.6	0.0	0.0	2.0
Noise levels in the facility	24.9	0.9	75.1	1.9	33.2	2.8	2.0
Safety of the facility	0.0	0.0	100.0	0.6	100.0	0.0	0.0
Staff attitude, body language or conduct, like staff being unkind, rude, or unhappy	100.0	0.9	0.0	0.0	0.0	0.0	0.0
Staff culture or facility culture (how staff work together or treat each other)	0.0	0.0	100.0	0.6	0.0	0.0	2.0
Staff not being adequately trained	33.4	1.9	66.6	2.6	50.0	2.7	0.0
Staff name badge/role not being displayed	66.8	1.9	33.2	0.6	0.0	0.0	0.0
Concerns about communication between staff, such as poor handover between shifts	100.0	5.6	0.0	0.0	0.0	0.0	0.0
Staff not being culturally sensitive (caring about my beliefs, values, spirituality, customs or religion)	100.0	0.9	0.0	0.0	0.0	0.0	7.9
Call bell not being answered	27.1	2.4	62.5	3.8	100.0	0.0	2.0
Understaffed or not enough staff on duty	48.4	5.8	51.6	4.2	50.0	2.8	2.0
Agency staff do not know me and my needs	33.2	0.9	66.8	1.3	100.0	0.0	0.0
Staff being mismatched to my preferences (e.g. not preferred gender)	55.3	1.9	44.7	1.0	0.0	2.8	2.0
Feeling safe in my room	0.0	0.0	100.0	0.6	100.0	0.0	1.2
The security of my room and possessions	62.0	0.9	38.0	0.4	100.0	0.0	3.9
Cleanliness and maintenance of my room and bathroom	50.0	3.4	50.0	2.3	66.7	2.7	5.9
Noise	58.4	5.2	41.6	2.5	75.0	2.7	2.0
The privacy of my room	66.7	1.9	33.3	0.6	100.0	0.0	9.0

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 (%)
Food, catering & dining experience	26.0	3.8	74.0	7.3	82.0	2.0	2.8
Social engagement with the community	49.8	1.9	50.2	1.3	100.0	3.2	0.0
Feeling lonely or bored	29.0	3.8	66.6	5.9	100.0	1.2	0.0
Access and reliability of internet/WIFI	76.7	1.9	23.3	0.4	100.0	3.9	0.0
Quality of laundry services	0.0	0.0	84.0	3.3	43.2	2.0	7.2
Having interesting lifestyle activities	53.7	2.8	46.3	1.7	100.0	0.0	0.0
Fees and charges (increasing or many additional costs/everything is an extra cost or confusing)	50.0	1.9	50.0	1.3	0.0	3.9	5.4
Any other concerns about being treated with dignity and respect	10.4	0.9	89.6	5.5	33.5	7.0	8.2
Any other concerns about choice	26.0	2.8	65.4	4.8	78.3	0.0	2.7
Any other concerns about personal care	0.0	0.0	100.0	2.3	0.0	3.1	2.8
Any other concerns about medical and health care	0.0	0.0	100.0	2.7	100.0	3.9	0.0
Any other concerns about the facility	46.6	3.8	53.4	2.9	100.0	0.0	0.0
Any other concerns about staff	64.9	2.8	35.1	1.0	0.0	3.1	2.8
Any other concerns about my room	45.5	2.8	54.5	2.3	61.7	2.0	2.7
Any other concerns about services and fees	33.5	0.9	66.5	1.3	50.4	0.0	2.7

* Main concerns unreported, 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 57: Most common reasons why residential respite clients did not discuss or report their main concerns

Main concerns	Share of all main concerns not discussed or reported (%)	Share of main concerns not discussed or reported because it was not worth complaining (%)	Share of main concerns not discussed or reported because clients did not have the capacity to complain (%)	Share of main concerns not discussed or reported because clients did not want to be a nuisance (%)
Understaffed or not enough staff on duty	5.8	6.4	4.0	0.0
Concerns about communication between staff, such as poor handover between shifts	5.6	4.1	8.0	4.0
Noise	5.2	5.0	2.5	7.9
Being treated like a child	4.7	5.5	4.0	0.0
Feeling lonely or bored	3.8	2.8	0.0	7.9
Having enough lifestyle activities to choose from	3.8	2.8	8.1	7.9
The way medication is managed	3.8	2.8	4.1	4.0
Food, catering & dining experience	3.8	2.8	4.0	11.9
Any other concerns about the facility	3.8	5.5	0.0	0.0
Choices about how and when to interact with other residents	3.4	5.0	10.5	0.0
Cleanliness and maintenance of my room and bathroom	3.4	0.0	0.0	6.4
Having interesting lifestyle activities	2.8	1.4	4.1	7.9
Any other concerns about choice	2.8	2.8	0.0	7.9
Any other concerns about staff	2.8	2.7	0.0	4.0
Any other concerns about my room	2.8	4.1	0.0	0.0
Choices about personal care, like choosing when to shower	2.8	1.4	0.0	3.9
How I am helped with personal grooming, like cutting nails or shaving	2.8	1.4	4.0	7.9
Accessing allied health services (e.g. physio, podiatry etc.)	2.5	3.6	6.5	6.4
Call bell not being answered	2.4	3.6	0.0	0.0
Staff not being adequately trained	1.9	1.4	4.0	0.0

Main concerns	Share of all main concerns not discussed or reported (%)	Share of main concerns not discussed or reported because it was not worth complaining (%)	Share of main concerns not discussed or reported because clients did not have the capacity to complain (%)	Share of main concerns not discussed or reported because clients did not want to be a nuisance (%)
Staff name badge/role not being displayed	1.9	1.4	0.0	0.0
Staff being mismatched to my preferences (e.g. not preferred gender)	1.9	1.4	0.0	3.9
Access and reliability of internet/WIFI	1.9	2.8	0.0	0.0
How client was helped with continence aids	1.9	2.7	8.0	0.0
The privacy of my room	1.9	2.7	0.0	0.0
Social engagement with the community	1.9	2.7	4.0	0.0
Fees and charges (increasing or many additional costs/everything is an extra cost or confusing)	1.9	2.7	4.0	0.0
Not being allowed to do certain things	1.5	2.2	4.0	4.0
Not being informed of daily routine	0.9	1.4	4.1	0.0
Seeing a GP when needed	0.9	1.4	0.0	0.0
The overall appearance of the facility	0.9	1.4	0.0	0.0
Any other concerns about services and fees	0.9	0.0	0.0	0.0
Continence pads (e.g. forced use, insufficient supply or changing)	0.9	1.4	0.0	0.0
Being shouted at by staff	0.9	0.0	0.0	0.0
Choices around the timing of meals	0.9	0.0	0.0	3.9
How I am helped to get around	0.9	1.4	0.0	0.0
Falls or fall prevention	0.9	1.4	0.0	0.0
Noise levels in the facility	0.9	1.4	0.0	0.0
Staff attitude, body language or conduct, like staff being unkind, rude, or unhappy	0.9	1.4	4.0	0.0
Staff not being culturally sensitive (caring about my beliefs, values, spirituality, customs or religion)	0.9	1.4	0.0	0.0

Main concerns	Share of all main concerns not discussed or reported (%)	Share of main concerns not discussed or reported because it was not worth complaining (%)	Share of main concerns not discussed or reported because clients did not have the capacity to complain (%)	Share of main concerns not discussed or reported because clients did not want to be a nuisance (%)
Agency staff do not know me and my needs	0.9	1.4	4.0	0.0
The security of my room and possessions	0.9	1.4	0.0	0.0
Any other concerns about being treated with dignity and respect	0.9	1.4	4.0	0.0
How pain is managed	0.6	0.0	0.0	0.0
How I am helped to shower	0.0	0.0	0.0	0.0
How I am helped with eating	0.0	0.0	0.0	0.0
How I am helped to use the toilet	0.0	0.0	0.0	0.0
How any wounds have been looked after	0.0	0.0	0.0	0.0
How catheters are used	0.0	0.0	0.0	0.0
Safety of the facility	0.0	0.0	0.0	0.0
Staff culture or facility culture (how staff work together or treat each other)	0.0	0.0	0.0	0.0
Feeling safe in my room	0.0	0.0	0.0	0.0
Quality of laundry services	0.0	0.0	0.0	0.0
Any other concerns about personal care	0.0	0.0	0.0	0.0
Any other concerns about medical and health care	0.0	0.0	0.0	0.0