Quality Domains for the Development of a Consumer Experience Report on Quality of Residential Aged Care

A Rapid Review Consultancy to the Australian Aged Care Quality Agency

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EXECUTIVE SUMMARY

Quality of residential aged care services has long been of great interest to the Australian public. The landscape of aged care is changing rapidly, as are consumer expectations of what aged care has to offer, how it is offered and by whom. Terms such as ‘quality care’, ‘quality of life’, ‘quality staff’, and ‘quality of care home’ are at the forefront of almost every government, industry and consumer organisation policy documents. Instigated by the Productivity Commission’s Caring for Older Australians Report 2011, major changes have been introduced by the Commonwealth Government, including the development of systematic processes for a consumer centric quality evaluation in the aged care sector. However, concerns about inadequacies of systems and processes for how such ‘quality’ is captured and conveyed in a meaningful way to all stakeholders, especially from the consumers’ perspectives, have yet to be resolved.

The Australian Aged Care Quality Agency (Quality Agency) has recently proposed to expand consumer input to quality reporting through a new Consumer Experience Report (CER). The CER will in turn complement the current processes for assessing the quality of care and services in residential aged care homes and support consumers in making an informed choice, with a CER published as part of each residential site audit report. In response to the project brief provided by the Quality Agency, and building on their recent paper Let’s Talk About Quality, this review investigates and reports on consumer views of quality care within the Australian aged care context, and points to approaches for more systematic collection and analysis of such information.

To identify the drivers of choice, we first examine the aspects of quality and information sources that consumers draw on prior to entry to residential care to guide their choice of homes. Second, to identify the aspects of care that are most important in shaping consumer experiences of quality of residential care after admission, we investigate a range of material including surveys of consumer satisfaction and in-depth studies of experience and outcomes. A rapid narrative review methodology was chosen to produce the evidence for developing a practical solution and decision-making, consistent with current policy, in a timely manner. The scope of this review was limited to Australian grey and academic literature published between 2006 and 2016. A total of 47 papers, 41 research papers and 6 reports, were included in the review.

This Rapid Review, conducted for the Australian Aged Care Quality Agency, has identified and made recommendations for a set of quality domains for the residential aged care sector.

For Drivers for choice of residential aged care home the following domains are recommended:

- Physical environment
- Location
- Maintaining identity
- Keeping independence
- Maintaining continuity
- Staff capability and care with respect and dignity
- Availability of care and health services at all times
- Trusting management

For key domains of quality for residential aged care home the following domains are recommended:
- Choice
- Respect and dignity
- Physical environment
- Social environment
- Functional environment
- Staff actions and interactions
- Organisational environment and resources
- Clinical and personal care

This work is a first step towards developing meaningful processes to better understand consumers’ experiences of residential aged care and the implications of the consumer experiences in determining ‘quality’ of care and services for the consumers, which in turn will help staff, service providers and policy makers further improve ‘quality’. The review also provides methodological considerations (sampling and question development) for the CER, to facilitate better and more comprehensive ways of capturing quality of care and services from consumers’ perspectives.
1. INTRODUCTION

1.1. BACKGROUND

In health and aged care services, quality has been traditionally decided by experts and measured and ‘certified’ by a government authority. This is now being challenged. The power of consumers and influence of consumer opinion has surged, enabled by accessible digital and media platforms. Consumers are now more empowered to determine for themselves what constitutes quality; and more adept at accessing and sharing information about the quality of such services.\(^1\)

Residential aged care homes are in a unique position to influence the life of those living in that setting. About a quarter of a million older Australians were in permanent residential aged care during 2014-15, which incurred over $10 billion in government expenditures.\(^2\) Residents in permanent care are largely female (68%) and aged 85 and over (61%); a third are born overseas (18% from a non-English speaking country); and 27% require a high level care across all three Aged Care Funding Instrument (ACFI) care need domains of activities of daily living, behaviour, and complex health care.\(^2\) For most of these residents, a care facility becomes their last ‘home’ before they die where their autonomy, choice, privacy and independence can be easily compromised. The care home—its environment, staff, care and services—unquestionably impacts on the resident’s overall wellbeing and quality of life, beyond clinical outcomes. Therefore, discussions around the care home’s quality, in both care and service delivery, and quality of life of the residents tend to overlap.

Quality of residential aged care services has long been of great interest to the Australian public, and ensuring quality standards of residential care services has largely been reliant upon the Australian Government through accreditation processes. The Quality of Care Principles under Australia’s Aged Care Act 1997 state:\(^3\)(p.6)

> The Accreditation Standards are intended to provide a structured approach to the management of quality and represent clear statements of expected performance. They do not provide an instruction or recipe for satisfying expectations but, rather, opportunities to pursue quality in ways that best suit the characteristics of each individual residential care service and the needs of its care recipients. It is not expected that all residential care services should respond to a standard in the same way.

However, what constitutes quality, how it is measured and what an acceptable level of quality is, has been a contentious issue for some time, with little progress made in resolving the issue of quality. Major progress was made as a result of the Productivity Commission’s Caring for Older Australians Report 2011,\(^4\) which recommended the need to increase choice, flexibility, consumer centredness, and quality in accommodation and care services for older Australians. The Commission’s Report underscored the need for the aged care sector and government to go beyond meeting the minimum standards and to increase consumer engagement in ensuring and monitoring quality of aged care and services. Consequently, the 2012 Living Longer, Living Better plan,\(^5\) and program reforms in the Coalition Government’s Healthy Life, Better Ageing\(^6\) followed. Some of the key aged care reforms include: Consumer Directed Care (CDC) initiatives; strict income and means testing through Centrelink, provision for accommodation bonds and increased accommodation payments for residential aged care; and the introduction of the My Aged Care website to assist consumers to make informed choices of care and services\(^7\). All these measures point to both increased consumer control and accountability of services as user
payments increase. These reforms further highlight the importance of providing consumers with opportunities not only to be informed of the choices that are available, but also to play a key role in determining what constitutes quality, how it is evaluated, what quality means to them as well as accessing information about quality of aged care and services that matters to them, not just to government and service providers.

The role of Australian Aged Care Quality Agency (Quality Agency) as an accreditation body for residential aged care services is paramount. The Quality Agency has therefore recently proposed to expand consumer input to quality reporting through a new Consumer Experience Report (CER). The CER will in turn complement the current processes for assessing the quality of care and services in residential aged care homes and support consumers in making an informed choice, with a CER published as part of each residential site audit report.

In response to the project brief provided by the Quality Agency, and building on their recent paper Let’s Talk About Quality, this review investigates and reports on consumer views of quality care within the Australian aged care context, and points to approaches for more systematic collection and analysis of such information. To identify the drivers of choice, we first examine the aspects of quality and information sources that consumers draw on prior to entry to residential care to guide their choice of homes. Second, to identify the aspects of care that are most important in shaping consumer experiences of quality of residential care after admission, we investigate a range of material including surveys of consumer satisfaction and in-depth studies of experience and outcomes. The review findings will inform the development of the CER by identifying the domains of quality of life and experiences of care that are of interest and importance to consumers of residential aged care. Notably, a plethora of research has been conducted in the areas of drivers of choice for and quality of care in residential aged care homes (RACHs), mostly from North America and Europe, but this review is purely based on recent Australian research findings and Australian consumer perspectives and experiences. It is the intention of the Quality Agency to capture what is known about the topic areas from the perspectives in Australia for the development of the CER, while acknowledging the use of only Australian evidence might be somewhat limited in comparison to the extant literature internationally.

1.2. METHODS

1.2.1. Design
This was a rapid narrative review, aiming to produce the evidence for developing a practical solution and decision-making, consistent with current policy. A modified method of Mays et al.’s work provided a framework for this type of review, called ‘decision support’, that is sensitive to a particular context and time, and involves a process of combining existing research evidence with expert opinions in the field of inquiry. The scope of this review was limited to Australian grey and academic literature published between 2006 and 2016.
1.2.2. Review questions

Question 1 - What are the key drivers for choice of a residential aged care home in terms of quality of care and services?

Question 2 - What are the key domains that capture consumer experiences of care and quality of services in residential aged care homes, with consumers here including residents, their families and significant others?

As stated in the project request, eight domains were identified for choice and for experience. Findings for each question are addressed separately in this report, with attention then given to the extent of commonality and difference between the two sets of domains.

1.2.3. Review procedures

1.2.3.1. Inclusion/exclusion criteria

The selection of materials for review depended largely on the relevance and objectivity of the information collected and interpreted. Given the nature of the intended use of the review findings, eliciting aged care consumers’ voice and experiences in Australia, it was appropriate to include both academic and grey literature that satisfied all of the following criteria:

1) relevant to the review questions;
2) based on consumers’ experiences and perceptions of care and quality of life in Australian RACHs, or staff and other stakeholders’ perspectives on quality of care and its impact on residents’ well-being;
3) published between 2006 and 2016; and
4) Papers were excluded if they focused solely on the effectiveness of an intervention/model of care/service delivery without a clear reference to its impact on the consumers’ experiences of quality of care and quality of life.

1.2.3.2. Searching relevant literature

The literature searches for both questions were carried out concurrently.

- Initial guidance for identification of potential materials and domains was provided by the Bupa Report - “Choosing a care home: A guide to finding your new home” - and the Aged Care Report Card Australia - “Choosing a Care Home: Care Home Checklist” (for Question 1); and the Aged Care Report Card - “Consumer Quality Rating Criteria” - and recent reports of the Aged Care Complaints System (for Question 2).

- Research literature: Electronic searches were carried out using broad search terms of “residential aged care” OR “nursing home”; quality; “choice” OR “decision-making”; Australia, were used to capture all potential papers. The research resulted in PubMed (n=665), APAIS: Australian Public Affairs Information Service (n=292); and Australian specific journals such as Australasian Journal on Ageing
2. LITERATURE SEARCH AND SUMMARY

2.1. SELECTING RELEVANT LITERATURE

The steps in the literature search and selection processes are set out in Figure 1.

A total of 1142 papers based on Australian studies and reports were identified through database searching, but after removing duplications and applying the selection criteria for inclusion and exclusion, 47 papers and reports were selected for review. Two researchers independently scanned titles and abstracts of these 964 papers for initial culling to select potentially relevant papers for the review. Any inconsistent selections were discussed and consensus was then reached to determine the final selection of papers for inclusion. Wide inclusion criteria were adopted and material was only excluded after it had been reviewed. This initial culling processes resulted in a removal of 901 papers including: 386 papers that were unrelated to the topic area or conducted outside Australia; 73 literature review papers which synthesised mostly non-Australian studies; and 442 papers that reported the outcomes of clinical care practices, programs and interventions, without reference to consumer perspectives and experiences, whether resident or family. Of 63 potential research papers examined, a further 22 papers were removed as they did not describe or discuss the experiences of consumers about residents’ quality of life or well-being, and quality care and services of RACH, whether it be from staff or consumers’ perspectives. Six reports were identified through the additional web searches described earlier.
When these six reports are added to the remaining 41 papers, 47 papers were finally selected. Of these, only 4 were deemed relevant for Question 1, 40 were deemed relevant for Question 2, and three were relevant to both Questions.

Figure 1. Search and selection processes
2.2. SYNTHESIS AND INTERPRETATION
Findings from the literature reviews have been integrated and analysed using thematic analysis. Initial themes and sub-themes were developed independently by the two researchers and consensus was then reached to determine the final key domains.

2.3. SUMMARY OF THE LITERATURE
The literature selected for review is summarised here in terms of the range of consumer and stakeholder input, the types of research methods, and the domains identified in quality appraisal tools and guidelines. Details of these aspects of the 47 papers are presented in Appendix A.

2.3.1. Consumer and stakeholder input
Several of the 47 papers included more than one group of consumers or stakeholders, with input reported from a total of 81 groups. In line with the primary focus of the review on consumers, residents’ experiences were the most commonly reported, in 23 studies, followed by family members in 16 papers; perspectives of residents and family members were both canvassed in eight of these papers. Another five papers included consumers without further identification, and the views of older people in the community were reported in a further five papers. Staff views were reported in 19 studies, and health care professionals in another seven. The remaining six groups of stakeholders included advocates, researchers, experts in the field, and service providers. Two papers that reported the development of questionnaires to identify quality domains did not report involvement of consumers or other stakeholders.

The overall consistency in the views expressed by these diverse groups points to a broad consensus on the main domains of quality, with some variations in emphasis on particular aspects of the main domains. The greatest difference was with reference to particular clinical aspects of care. As noted above, a sizeable number of papers (n=442) that reported on clinical aspects of quality but not from a consumer perspective were excluded from the review. A limited number of clinical and care related papers were deemed relevant for the review through their reference to consumers’ perspectives and experiences. Furthermore, most of these selected papers on clinical care aspects only touch briefly on the impact of clinical care on quality of life of residents and the experiences of residents and their family members, so provide only limited scope for discussion.

2.3.2. Research approaches
Qualitative methods were by far the most common type of research, with 29 qualitative studies compared to only six quantitative studies and five that used mixed methods. The scale of the studies varied widely. Qualitative studies that sought views from residents and family members typically involved between 15 to 50 of each group; similar numbers of staff and other stakeholders were covered in studies reporting these inputs. The quantitative studies and quantitative components of mixed methods studies surveyed larger numbers, with the two large scale surveys of older people in the community reporting on over 1000 respondents. The consistency of findings derived from different research methods is again notable.
2.3.3 Tools and guidelines

The literature search identified three quality appraisal tools developed by the Aged Care Report Card Australia (ACRCA) and Bupa for use by consumers, and six guidelines/checklists based on consumers’ input (as well as other key stakeholders’ input) concerning residential aged care quality. Further details of these items are given in Appendix B. The two sets of guidelines developed by Alzheimer’s Australia that focused on dementia care identified very similar domains so they are combined, and the two ACRCA tools were also combined because of their similarity; 6 items rather than 8 tools and guidelines are thus reported below.

Whilst these tools/guidelines are assessing different aspects of quality (e.g. consumer satisfaction, indicators of quality, a checklist for quality, and quality standards), given that the aim of this review was to elicit key consumer driven domains of quality in residential aged care, it was deemed appropriate to canvass the key topic areas and questions from those tools/guidelines in reference to the domains and key elements elicited from the thematic analysis of the papers reviewed. Eight domains are detailed in terms of their key elements in Table 1. A total of 37 key elements were identified; seven of the domains had two to five key elements, with the Clinical and Personal Care Domain having 14. This snapshot of the domains of quality residential aged care demonstrates the wide spread of the key elements across all the tools, but at the same time, the 13 identified in five or six of the six items stand out as the core of quality domains (shown in bold in Table 1). Another 15 key elements were identified in three or four of the six items, and nine were identified in only one or two (shown in lower case in Table 1). Most of the last nine were elements of Clinical and Personal Care; the lower identification of these elements is in large part a result of the exclusion of many papers reporting clinical aspects of quality from the review and should not be taken as meaning that clinical and personal care are not important to consumers.
Table 1. Key domains of RACH quality in relation to quality appraisal tools/guidelines

<table>
<thead>
<tr>
<th>Key domains</th>
<th>Key elements</th>
<th>ResCare QA</th>
<th>Client Perception of Value</th>
<th>Quality Dementia Care: Managers / Staff</th>
<th>NACA Quality Indicator</th>
<th>Aged Care Report Card</th>
<th>Choosing a care home (Bupa)</th>
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<tr>
<td>Choice</td>
<td>Preferences, independence and autonomy</td>
<td>X</td>
<td>X</td>
<td>X / X</td>
<td>X</td>
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<tr>
<td></td>
<td>Individualised, culturally sensitive</td>
<td>X</td>
<td>X / X</td>
<td>X / X</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>Respect and Dignity</td>
<td>Personhood</td>
<td>X</td>
<td></td>
<td>X / X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td></td>
<td>Personal belongings, privacy and confidentiality</td>
<td>X</td>
<td></td>
<td>X / X</td>
<td>X</td>
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<td>X</td>
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<tr>
<td></td>
<td>Being consulted</td>
<td>X / X</td>
<td></td>
<td>X / X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td></td>
<td>Being valued and feeling useful</td>
<td>X / X</td>
<td></td>
<td>X / X</td>
<td>X</td>
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<td>X</td>
</tr>
<tr>
<td>Physical Environment</td>
<td>Safe &amp; secure</td>
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<td>X / X</td>
<td>X</td>
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<td>X</td>
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<tr>
<td></td>
<td>Cleanliness, hygiene, smell</td>
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<td>X / X</td>
<td>X / X</td>
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<td>X / X</td>
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<tr>
<td></td>
<td>Welcoming and homelike</td>
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<td></td>
<td>X / X</td>
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<td>Supportive facilities encouraging social health</td>
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<td></td>
<td>X / X</td>
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<td>X</td>
<td>X / X</td>
</tr>
<tr>
<td>Social Environment</td>
<td>Meaningful, leisure activities</td>
<td>X</td>
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<td>X / X</td>
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<tr>
<td></td>
<td>Social interaction opportunities</td>
<td>X</td>
<td></td>
<td>X / X</td>
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</tr>
<tr>
<td></td>
<td>Tailored programs</td>
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<td></td>
<td>X / X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Functional Environment</td>
<td>Opportunities for rehabilitation/enablement</td>
<td>X</td>
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<td>X</td>
<td>X / -</td>
<td>X</td>
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<tr>
<td></td>
<td>Mobility and physical exercise</td>
<td>X</td>
<td></td>
<td>X / X</td>
<td>X</td>
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<tr>
<td>Staff Actions and</td>
<td>Communication and relationship building</td>
<td>X</td>
<td></td>
<td>X / X</td>
<td>X</td>
<td>X</td>
<td>X / X</td>
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<tr>
<td>Interactions</td>
<td>Partnership with family members</td>
<td>X</td>
<td></td>
<td>X / X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td></td>
<td>Caring, friendly and responsive to the needs</td>
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<td>X / X</td>
<td>X</td>
<td>X / X</td>
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<tr>
<td>Organisational</td>
<td>Adequate staffing and stability</td>
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<td></td>
<td>X / -</td>
<td>?X</td>
<td>X / x</td>
<td>X</td>
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<td>Environment and Resources</td>
<td>Access to allied health, GP &amp; other services</td>
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<td>X / -</td>
<td>X</td>
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<tr>
<td></td>
<td>Feedback/complaints mechanisms</td>
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<td>X / -</td>
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<td></td>
<td>Information exchange system</td>
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<td>X / -</td>
<td>X</td>
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<tr>
<td></td>
<td>Staff education &amp; development opportunities</td>
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<td></td>
<td>X / -</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Clinical and Personal Care</td>
<td>Hydration and Nutrition</td>
<td>X</td>
<td></td>
<td>X / X</td>
<td>X / X</td>
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<tr>
<td></td>
<td>Assessment &amp; care plan</td>
<td>X</td>
<td></td>
<td>X / X</td>
<td>X</td>
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<td></td>
<td>Pain management</td>
<td>X</td>
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<td>X / X</td>
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<td>X / x</td>
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<tr>
<td></td>
<td>Falls prevention and management</td>
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<td>X / -</td>
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<td>Behavioural management</td>
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<td>Skin care/Pressure injury</td>
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<td>X / X</td>
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<td></td>
<td>Infection control, communicable outbreaks</td>
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<td>X / X</td>
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<td>Depression, anxiety and emotional wellbing</td>
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<td></td>
<td>Care of senses</td>
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<td></td>
<td>Continence management</td>
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<td>Palliative care, advance care plan</td>
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<td></td>
<td>Medication management</td>
<td>X</td>
<td></td>
<td>X / x</td>
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<tr>
<td></td>
<td>Sleep</td>
<td>X</td>
<td></td>
<td>X / x</td>
<td>X</td>
<td>X / x</td>
<td>X</td>
</tr>
</tbody>
</table>

Notes: * “Consumer Quality Rating Criteria” and “Choosing a Care Home: Care Home Checklist” by Aged Care Report Card Australia are identical.
- X Elements discussed.
- - Elements not discussed.
- ? not confirmed.
- Clinical care.
- Personal care.
3. FINDINGS

This section reports our findings from the review of all 47 papers (both grey and academic literature). Whilst the domains from the six reports were a guide, we made our own domains from the review of the entire papers selected; they compare closely to the report domains and we discuss this later.

3.1. DRIVERS FOR CHOICE OF A RESIDENTIAL AGED CARE HOME

3.1.1. Physical environment

The physical environment and its characteristics played a leading part in decision-making about choice of RACH prior to admission. Overall cleanliness was a high priority as well as a clean, spacious and odour-free room.\(^{15,17}\) Other important features included: having their own en suite;\(^ {18}\) a homely environment with comfortable noise levels and a neutral or pleasant smell;\(^ {15,16}\) and privacy and personal spaces, security and safety of facilities including outdoor areas and private areas for visitors.\(^{16}\)

3.1.2. Location

Geographical proximity to family was also a factor in RACH admission decision-making as it would enable regular visits. This was a factor for both prospective residents and families/significant others in their selection of specific facilities.\(^{17,18}\) Social isolation of residents precipitating admission must also be considered as longitudinally better confidante networks and better total social networks were associated with reduced odds of nursing home admission, suggesting a close, emotionally supportive relationship with another person is beneficial in preventing or delaying nursing home use.\(^{19}\) The core network of confidantes, and to a lesser extent children, was pivotal in delaying or preventing use of RACHs.\(^{19}\)

3.1.3. Maintaining identity

Residents from Culturally and Linguistically Diverse (CALD) backgrounds have been found to preference RACHs that enable them to continue practising aspects of their culture. Their preference was demonstrated through a number of activities including language and food alternatives,\(^{15,17}\) discussing their migration experience, family and beliefs, and practising music and dance.\(^{20}\) Incorporating these features into residents’ daily activities helped residents settle better following admission to a RACH. Relaxing with music from their own culture was one of the strategies that helped residents remember people, places and emotions from the past.\(^{20}\) These findings had two implications for care facilities: employment of staff possessing bilingual abilities; and staff awareness of a prospective residents’ cultural preferences that may enable them to better support families’ decision-making processes.\(^{17}\) For example, it was important to have understanding of cultural expectations of elder family members being cared for by their children and that this expectation could be challenged by the prospect of moving to a residential aged care facility: “information targeting people from a Chinese background could emphasize that nursing home placement is not about abandoning the person, and that the caregiver will continue to be involved in the person’s care.”\(^ {17(p.423)}\) The need for maintaining individual identity extends beyond the individual’s CALD background. RACHs ability to support residents’ generational, spiritual, cultural, sexual, and religious needs and their staff being able to value and understand residents’
differences in beliefs and needs when delivering clinical care, were found relevant for all regardless their CALD backgrounds. 15 16

3.1.4. Keeping independence
In choosing a RACH, prospective residents fear losing their independence, with women considerably more concerned about this than men. Individuals also expressed dread of the thought of living in a RACH. Self-rated good-to-excellent health and having no hopes for the future were associated with fear of RACH admission. 21

The importance of understanding each resident’s abilities and supporting them to be independent as well as having the option to engage in activities independently, while providing choice and control over their lifestyle, were also found in the Bupa guide 16 and ACRCA checklist. 15

3.1.5. Maintaining continuity
Continuity and familiarity were also relevant to potential residents’ decision-making. This domain included their desire to find a facility where the prospective resident’s GP could continue to visit 17 and to stay within the same aged care organisation on the same site, such as a retirement village. 18

3.1.6. Staff capability and care with respect and dignity
Staff competence, particularly that of senior and supervisory staff, and their attitudes towards and interactions with residents were also important factors. 18 Staff treating residents with dignity and respect was also identified as central to good quality care, for example using the resident’s name or title and developing a genuine relationship as well as staff being attentive and offering comfort and support if a person is unhappy or distressed. 15 16 Confidence with the skill level of staff attending to any complex or chronic needs as well as staff showing reasonable compassion and dedication toward residents with a friendly and welcoming demeanour for residents and their visitors were identified as quality factors. 15

3.1.7. Availability of care and health services at all times
A strong presence of nursing and care staff and quick responses to a resident’s call for assistance were identified as crucial to choosing a RACH. 15 The ability to access care at all times and particularly at night was the central consideration for residents in one study. 18 The ACRCA checklist further extended this domain in terms of the importance of accessibility of residents to allied health services such as a dietician, speech/physiotherapy, and prompt GP attention when required. 15

3.1.8. Trusting management
Trusting facility management was also associated with good quality care. 17 Having access to management who are responsive to residents’ concerns was identified as an important factor for RACH admission decision-making. 15
3.2. CONSUMER EXPERIENCES OF CARE AND QUALITY OF SERVICES IN RESIDENTIAL AGED CARE HOMES

3.2.1. Choice

3.2.1.1. Preferences, independence and autonomy

Enabling residents to express their preferences in a number of facets of life in RACH and so maintain their independence and autonomy was the main considerations in the delivery of high quality RACH. The loss of control for residents upon entering a facility compared to their previous lives was keenly felt. Residents expressed preferences and choices in different ways including: the ability to go outside and not being locked inside (freedom of movement); having independence, autonomy and flexibility in their daily routine; continuing small daily pleasures such as having their hair done, watching TV, having a massage or visiting with their families; feeding birds in the garden at particular times of day and ‘saving a spot’ for someone to sit or having a favourite chair where they preferred to sit, which in one study were strongly discouraged by the staff or not permitted, despite the fact that sitting in the same chairs at mealtimes enabled previous conversations to continue. Having such opportunities for choice and control was closely linked with a heightened sense of self, a sense of normality and freedom and wellbeing. The importance of recognising and incorporating choice in daily living and care is also supported by Alzheimer’s Australia and the National Aged Care Alliance (NACA). Independence could be further reinforced by encouraging residents to complete tasks for themselves, or with direction, and maintaining community involvement. Experiencing loss of control was also keenly felt by residents according to their gender. In one study, male participants talked about occupying the role of the patriarch in their families, a position entailing substantial power, control and independence, which they viewed as threatened by admission to a RACH. The importance of friendships and social interaction was also emphasised in that study with men overwhelmingly citing a desire to share a room as opposed to having their own single accommodation. It was also important for staff to respect residents’ religious preferences and their ability to practise their spirituality. The importance of pastoral care as providing spiritual support, emotional support and practical support was also identified.

3.2.1.2. Individualised, culturally sensitive care

The provision of individualised, culturally sensitive care was another factor essential for the delivery of quality care. In one study, participants consistently equated providing good quality care with being identified and respected as a person with individual likes, dislikes, preferences and needs. Being able to express personal preferences, and having them respected permeated virtually all discussion surrounding the meaning of good quality residential care. This aspect of quality extended to the provision of individualised rather than generic activities. Individualised care was also a factor in quality palliative care within RACHs where care was relationship-focused and involved committed engagement and collaboration and shared decision-making between the resident, family and staff. Enabling residents from CALD backgrounds to continue to practice their culture through using their language of choice and engaging in activities such as music and dance was
shown to have positive effects on residents wellbeing following RACH admission.\textsuperscript{17, 20} This aspect was further supported by Alzheimer’s Australia,\textsuperscript{11, 12} which advocates for the use of interpreters for CALD residents to ensure their preferences are being fully communicated to care staff and that values, beliefs, cultural and spiritual needs should be assessed over time. Using labels in the person’s preferred language on cupboards or on items the person uses, such as hairbrushes and slippers, as well as recognising culturally specific artifacts and making them available, such as posters, food, films, books, or television programs, were recommended.\textsuperscript{12} Valuing and understanding cultural and religious beliefs when delivering care was also identified in the ACRCA quality criteria.\textsuperscript{14}

3.2.2. Respect and Dignity

3.2.2.1. Respecting personhood
The importance for RACHs and staff supporting the personhood of residents is paramount to achieving high quality care.\textsuperscript{23} This aspect of quality was achieved through interpersonal interaction and documentation. One study found that residents’ social identity was impacted upon admission to an RACH as they were assigned a medical record number, with this depersonalising effect compounded by staff all too frequently referring to those in their care with titles such as ‘Room 76’, or labelling residents as ‘incontinent’, ‘immobile’ or ‘confused’.\textsuperscript{22} In the case of residents with dementia, labelling them as a diagnosis or behaviour was seen as dehumanising, disrespectful and contributing to poor outcomes.\textsuperscript{23} Lack of dignity and respect for residents and their families was also reflected in documentation where staff referred to a resident’s actions as non-compliance, moodiness and being difficult rather than the person’s expression of a need.\textsuperscript{27} Being treated with dignity and respect as a crucial element of quality care was also supported across all grey literature.\textsuperscript{11, 14}

3.2.2.2. Respecting the need for being valued and feeling useful
Residents’ need to feel useful and valued in their daily lives and activities as part of supporting the dignity of individuals and their wellbeing and achieving the delivery of high quality care. Male residents used terms such as futile, demeaning, directionless and boring in reference to their lives in the RACH and universally referred to a continued need for meaning.\textsuperscript{22} In another study residents derived a sense of personal satisfaction and the feeling of being useful through helping with jobs and assisting other residents within the facility and also externally through contributing to family life by attending or being included in important family milestones, or providing advice to family members.\textsuperscript{23} Connection between roles in their previous lives and activities in the RACH (e.g. a lay preacher being able to still counsel his friends, family and other residents) was a further dimension of feeling useful and valued.\textsuperscript{25} These factors were further supported by NACA\textsuperscript{13} who identified resident experience of empowerment and feeling that they made a contribution as two quality indicators.

3.2.2.3. Respect for personal belongings, privacy and confidentiality
Staff and management respect for individual residents’ privacy, personal space and personal possessions was a decisive factor for delivering high quality residential aged care.\textsuperscript{30} Provision of a variety of spaces for privacy was associated with higher quality of life.\textsuperscript{31} Indeed, residents often experienced loss of privacy through sharing
bedrooms and bathrooms. One study noted that “the very nature of institutional life precludes the existence of true privacy.” Examples of their desire to have privacy and personal space included: having enough space for personal belongings; the ability to personalise the individual’s room; a sense of mastery over one’s own space; as well as private access to their own bathroom and the availability of private spaces outside one’s bedroom. Maintenance of privacy through confidential storage of resident documents and medical records was also a crucial feature of quality care in RACHs. Whilst accepted as best practice, the performance of this principle was not always optimal. In one study, three of the fourteen sites had medical records, personal care charts, continence charts and pressure area care documentation in places that were freely available for non-authorised people such as visitors to access. Awareness of differing personal requirements for privacy, including person-based recognition of modesty as well as cultural preferences for privacy were identified by Alzheimer’s Australia. The ability to personalise rooms with possessions and ensuring a safe return and storage of residents’ clothing was a further mark of quality.

3.2.2.4. Being consulted
Residents often accepted their limited role in decision-making about the health care they received once they had become resident in an RACH. In a study of decision-making about transfers from an RACH to an emergency department, residents reported being resigned to having someone else make decisions for them and yet were reassured by hospital transfer and derived a sense of safety from it.

3.2.3. Physical Environment

3.2.3.1. Supportive facilities and physical features that enhance social interactions, links with community, and daily activities
The physical features of facility spaces were an indicator of quality for residents. Residents’ self-reported quality of life is highly associated with buildings that facilitate engagement with a variety of activities both inside and outside, with easy access to the local community, provide alternatives to wandering, are familiar, provide a variety of private and community spaces for social contact according to individual preferences and the amenities and opportunities to take part in domestic activities. Other relevant physical features of the facilities included: adequate spaces and furniture to encourage family participation in activities; dining environments that promote conversation and socialising; and rooms relevant to local cultural diversity such as prayer rooms and the proximity to amenities. One environmental audit tool also included items such as visual access, stimulus reduction and enhancement, movement and engagement.

3.2.3.1. Safe and secure
The safety and security of facilities was an integral aspect of quality. This included features such as closed circuit TV monitoring being used for the security of residents. Notably, residents’ family members were aware of the need for a balance between managing risk and having a safe environment, and other aspects of good quality care, such as maintaining physical health through physical activity, and respect for the individual’s control over their own decisions. Residents’ sense of safety, security and comfort was identified as a quality
indicator by NACA, which also referred to the number of ‘elopements’ and assaults of residents as additional quality indicators.13

3.2.3.2. Cleanness, hygiene, smell
The cleanliness of facilities – both communal spaces and residents’ rooms, as well as the appearance of the facility grounds being neat and tidy – was considered a fundamental marker of quality.10 18 23 36 Having an odour-free room was an additional dimension of quality.17 The importance of cleanliness of the physical environment was also highlighted in the NACA quality indicators and ACRCA quality criteria.13 14

3.2.3.3. Welcoming and homelike
A welcoming environment for residents and their visitors was emphasised in a number of papers. This attribute included families being welcome to visit the facility and participating in the community at the facility.10 37 Other welcoming and homelike features considered as a marker of quality included: an inviting environment for the visit of children, not just those related to the resident;22 the general appearance of the external gardens as well as the proximity to the local village shops and businesses;36 and no excessive noise which was considered detrimental to a welcoming environment.27 In terms of residents’ own rooms, the importance of a homelike feel was also identified. In contrast to a more clinical feel, a homelike environment helped their adjustment to the facility by minimising anxiety. A homelike feel was characterised by having access to private spaces outside of their own room, for example small lounges, or reading nooks, or having ornaments on the tables, and outdoor spaces with trees and gardens as an extension of this homelike feel.23 The importance of a homelike atmosphere was also identified across all grey literature.11-14

3.2.4. Social Environment

3.2.4.1. Tailored programs
The ability to tailor care according to the needs and preference of the individual was seen as a signal of quality in terms of achieving good outcomes for the residents. This signal was particularly the case for family members of dementia residents who believed that kind, respectful staff who could get to know residents’ preferences would be able to tailor care and management to individuals.23 The availability of a range of optional activities that were consistent with residents’ preferences and religious and cultural beliefs, as well as their different physical and intellectual abilities, was also identified as contributing to quality care in the ACRCA quality criteria and Alzheimer’s Australia guidelines.11 12 14

3.2.4.2. Meaningful, leisure activities
Availability of both solitary and group activities was an important marker of quality.9-12 14 34 Participation in activities contributed much by enhancing residents’ social networks and friendships38 and overall quality of life.39 Residents sometimes attended activities for social reasons rather than for the enjoyment of the activity.34 Activities included both within facility and excursions/outings with disappointment being expressed when such outings were reduced.34 36 The gender appropriateness of activities also needed to be considered as well as the ability to participate in community-based social activities.22 Whilst resource constraints (e.g. limited bus seat
numbers) and residents’ health conditions (e.g. poor eyesight) at times limited the availability, content, variety and delivery of activities, fostering social relationships with others played an important part in activity participation, and in combating the potential for social isolation and depression, especially for male residents. Activities that were meaningful to residents, those through which they could continue to express their personhood, and that could be tailored to their interests and preferences were found to be most relevant to quality, rather than people being offered more traditional diversion activities with no context to participants. Meaningful activities were also helpful for alleviating boredom. At the same time, the option for solitary as well as group activities should be offered according to preferences. Activities also gave residents a sense of purpose and opportunities for personal growth as did helping other residents with mealtimes, exercise or games. Family were influential in resident activity participation either providing transport to activities outside of the RACH or encouraging participation in facility based activities. Activities underpinned by the Montessori approach, which focuses on the abilities and capabilities of each resident as well as their background skills, likes and dislikes, were found to enhance the person-centred approach to care for residents with dementia. Alzheimer’s Australia recommended that activities should be comprehensive, flexible and diverse, including reminiscence, reality orientation, music therapy, pet/doll therapies and sensory experiences as well as everyday activities such as folding laundry, and be available easily and regularly.

3.2.4.3. Social interaction opportunities

The importance of maintaining a connection to social contacts outside the facility was perceived by residents as “a continuation of life and, as such, the cessation of contact was universally identified as a form of abandonment and was perceived as an indicator that their participation in society had ended.” Access to family and regular visits were important for residents for providing social support and a connection to their lives prior to RACH admission. The ability to form friendships with other residents was also seen as key. Socialising with other residents during meals and sitting at the same table each day helped facilitate the formation of friendships. Informal opportunities for interaction in the home’s dining room also helped to forge these relationships. ‘Adequate social and community connections’ was also identified as a quality indicator in the NACA quality indicator report.

3.2.5. Functional Environment

3.2.5.1. Opportunities for rehabilitation/reablement

Opportunities to engage in active ageing programs were also identified as a marker of quality. By keeping physically and mentally fit as possible, residents were better able to cope with difficult health problems. However, some residents found too many extra activities to be overwhelming, and it was recommended that a more flexible and inclusive approach to active ageing that allows residents to create their own forms of activity be adopted. This aspect of quality also includes having a stronger focus on residents being mentally active rather than socially active.
3.2.5.2. Mobility and physical exercise
The importance of mobility and physical exercise for resident quality of life was also identified. A focus on both physical health and activities of daily living support was emphasised by family members. Anumber of studies referred to the need to incorporate residents’ autonomy and choice in providing mobility care. Residents strove to be as mobile as possible within their physical limits, but staff often assumed control of residents’ mobility and did not always negotiate with residents, which created a tension between staff considered helpful and those viewed as controlling. It was also found that “scrutiny is required of mobility care conducted with residents who are passive or have learned to be dependent as such residents may be at risk of receiving substandard mobility care; care that is unsafe, uncomfortable or does not meet residents’ needs.” Good mobility care was founded on considerations of resident choice, autonomy and the value of mobility. Provision of quality mobility care was also found to be important by Alzheimer’s Australia. This aspect of quality included availability of mobility aids that encourage mobility and independence, availability of rehabilitation programs and the existence of a falls prevention program at each facility. The offer of regular exercise classes and activities was also suggested as beneficial for mobility, focusing on the person’s ability and praising small achievements to raise their self-esteem.

3.2.6. Staff actions and interactions with residents and family
3.2.6.1. Communication and relationship building
Staff ability to listen to and communicate well with residents was a widely recognised aspect of care quality. Having good communication skills is a building block for developing meaningful relationships and developing and maintaining relationships between family members, residents and staff that contribute to care quality. Staff communication using techniques appropriate to each residents’ capabilities and preferences was recognised particularly for residents with dementia, and resident experience of positive relationships, including with staff, was identified as a quality indicator by NACA.

3.2.6.2. Partnership with family members
Staff being able to work in partnership with family members was a major feature of care quality. These partnerships took various forms including engaging family in the assessment processes (e.g. identifying the resident’s preferences, beliefs and choices), care planning and decision-making associated with care and treatment of residents (e.g., emergency transfers, medications, end of life care). Responsiveness to family members’ questions and welcoming them to participate in facility activities were also highly regarded. Family-perceived involvement was significantly and positively correlated with satisfaction and facility impressions. For family members, knowing that staff took time to acknowledge their presence and that they shared a common goal gave them a sense of control in determining the quality of their relative’s life at the RACH. The importance of keeping family well informed of residents’ health and involving them in care planning was also identified in the ACRCA quality criteria. Keeping family members up to date about changes and relevant information was an important aspect to quality care, and fundamental to the success of a continuing
partnership with the family. A range of information valued by family members included: the resident health conditions, management issues that affected how the facility was run, changes in the resident’s care needs and plan, and information on the sale obligations and unit values of the RACH.

3.2.6.3. Caring, friendly and responsive to needs in a timely way and adequately

The interpersonal expertise of staff and management was crucial for residents’ experience of quality care. Being responsive to needs and adopting a caring and friendly manner were examples of these skills. Care staff being alert and responsive to the needs of residents with dementia (e.g. helping the person to access a garden or courtyard and providing opportunities for socialisation and/or privacy) contributed to the success person centred care. Approachability of management was also viewed positively by residents as creating a harmonious environment. The ‘quality of affection’ shown to a resident was a valued interpersonal aspect of the care they received, with feeling ‘cared for’ being associated with decreased feelings of loneliness for residents when their families had not visited. Knowing that the resident was receiving good interpersonal care that was meaningful to them also enabled family members to feel comforted about the care their relative received. Conversely, staff spending inadequate amounts of time with residents for personal care tasks was viewed as having a negative impact on quality of care. The ACRCA quality criteria further expanded on qualities of staff, including the ability to respond quickly to calls for assistance, adopting a friendly and welcoming demeanour when interacting with residents and visitors, and their compassion, dedication and responsiveness.

3.2.7. Organisational Environment and Resources

3.2.7.1. Staffing and stability

A number of factors at an organisational level had critical implications for residents and their families’ views on the quality of care they received at RACHs. Primary amongst these was the employment of adequate numbers of properly trained staff with continuity of staffing highlighted as a central factor. Staffing issues impacted on the relationship between families and the home’s management. Casual and non-permanent staff were frequently seen to be less capable by families and this perception became a notable impediment to the formation of a collaborative relationship. In another study, families perceived differences in care quality and well-being for people with dementia between weekdays and weekends, and the differences were attributed to lack of regular staff. Shortages of adequately trained staff were viewed as having implications not just for quality but also the safety of residents, and the ability of staff to adopt individualised approaches to caring for each resident. One study identified that continuity of staff made it easier for GPs to treat residents and facilitates trust in the nursing staff. Notably, having confidence in the abilities of the staff was essential to the establishment of a collaborative relationship. Family members needed to know that staff had the knowledge and skills to give appropriate care and moreover, competently manage any incidents as they arose. Seeing the staff as competent and approachable generated confidence for the family, however, the abilities of the staff were never taken for granted. When they were visiting, families continued to observe and monitor the care delivered and judged staff on the basis of what they observed. Families particularly scrutinised the actions and behaviours of staff at times
when the resident was vulnerable such as when they were ill or when medications were being administered. Confidence in the skills of staff was also identified in the ACRCA quality criteria.

3.2.7.2. Information exchange system

Successful communication and coordination of accurate and reliable clinical, residential and administrative data in a timely way has been shown to be essential for the delivery of high quality care in RACH even if not in the forefront for consumers. The importance of cross-professional and cross-institutional collaboration and integration was demonstrated for the successful transfer of people and information between RACHs and other healthcare facilities including hospitals and GP clinics. The coordination of resident information from multiple sources and within and between different facilities was also critical for ensuring the safety of care delivery. IT systems that were inter-operable between RACHs, GPs and pharmacists would allow more efficient and reliable information exchange between facilities and external providers and also enhance internal communication processes such as handover. Electronic health record use in RACHs was found to have benefits not only for individual care staff members and the RACHs, but also for residents in terms of improvement in the quality of individual residents’ health records, higher quality of care and smoother communication between residents and staff. The importance of communicating adequately with family and residents regarding upcoming events whilst maintaining confidentiality of residents’ records through a good information exchange system was also identified as a quality standard by Alzheimer’s Australia.

3.2.7.3. Staff education and development opportunities

A number of facets to staff education and development were recognised as markers of quality care. Staff were required to have skills not only in care, but also staff–family-resident dynamics, conflict resolution and customer service. Adequate levels of staff education, training, and confidence were identified by families as important for care quality; the need paramount in reference to the care of residents with dementia requiring additional training and a special set of skills. Families viewed the lack of dementia care training, and staff with insufficient training in dementia care as hampering the provision of individualised care. Specialised skills in providing oral care were also found lacking. In one study staff reported that they did not receive regular oral health education and training and that much of their learning was ‘done on the job’ and dependent on ‘common sense’. They expressed the need for education and training in identifying oral health problems and managing oral hygiene in residents who exhibited resistive behaviours.

3.2.7.4. Access to allied health, GP, specialist and other services

Access to healthcare providers and services outside the RACH was emphasised as a feature of high quality aged care. In one study of residents with dementia, family members thought that good quality healthcare would be holistic, and not confined to dementia management alone. Access to ‘extra’ healthcare services, such as podiatry, dental and allied health was valued. It was felt that access to good quality healthcare services, which considered a broad range of health conditions, would improve the outcomes of the individual. In another study, access to GPs was found variable and many limited their consultation time. Access to oral health services was particularly limited in a rural RACH. Dentists rarely came to the aged care services, and the residents did not
receive regular oral health checks. The importance of timely access to GP care and availability of allied health care was also identified by the ACRCA quality criteria\textsuperscript{14} and Alzheimer’s Australia’s guidelines\textsuperscript{11} and access to health and medical services was recognised as a quality indicator for NACA.\textsuperscript{13} Expectations of the care available at RACHs were also mentioned with the expectation of more than first aid being available at the RACH\textsuperscript{16} and care available at all times and particularly at night.\textsuperscript{18} Furthermore, residents were found to use complementary medicines, often covertly and usually to manage pain and improve mobility, and with the financial assistance of their families.\textsuperscript{52} RACH staff and management were wary of complementary medicine use in older people given a lack of evidence to support the safety and efficacy of such medicines, limited facility policies, often requiring medical approval, and additional cost. However, families believed complementary medicine should be a legitimate health care option in RACH.\textsuperscript{52}

3.2.7.5. Feedback/complaints mechanisms
The responsiveness of management in listening and responding to resident feedback along with visibility of the organisation’s values and objectives was identified as central to quality in the ACRCA quality criteria.\textsuperscript{14} Alzheimer’s Australia also highlighted the importance of having mechanisms for residents and families to voice their concerns and complaints without fear of repercussion or victimisation.\textsuperscript{11}

3.2.8. Clinical and personal care
3.2.8.1. Assessment and care plan
Conducting appropriate and timely assessment and care planning, which requires regular reviews and flexibility to account for changes in residents’ abilities and preferences, by competent staff, was recognised as an important feature of care quality\textsuperscript{10-13 51} but also implicitly recognised in most clinical and personal care areas.

3.2.8.2. Clinical care
Providing timely, appropriate and adequate clinical and personal care is critical in determining quality of residential aged care, although less prominent in consumer accounts. Key clinical areas repeatedly identified in Guidelines and in a few other papers are:

1) Timely palliative care, including end of life care and advance care planning;\textsuperscript{11 12 29 53 54}
2) Quality use of medicines involving regular review of residents’ medications for appropriateness of prescription as well as assessment of residents’ competency for self-management of medication and medication compliance, and the risk of medication interactions and side effects;\textsuperscript{9 11-12}
3) Adequate pain management including regular, skilled assessment of pain and the use of both appropriate pharmacological and non-pharmaceutical interventions such as use of hot or cold packs, massage, and relaxation;\textsuperscript{9 11-13}
4) Falls prevention and management;\textsuperscript{9 11 13}
5) Behavioural management involving comprehensive assessment of triggers or factors that may have caused behaviours of concern and use of non-pharmaceutical/psychosocial interventions initially, and appropriate use of restraints only if all other attempts have failed;\textsuperscript{9 11-13}
6) Skin care involving prevention and management of pressure injuries, consistent observation of skin integrity, and provision of safe environments (e.g. sun protection); \textsuperscript{9, 11-13}

7) Adequate infection control protocols including staff handwashing, toileting hygiene measures, procedures for dealing with infectious outbreaks, especially for residents with dementia; \textsuperscript{9, 11-13}

8) Management of depression, anxiety and emotional wellbeing \textsuperscript{11-13}

### 3.2.8.3. Personal care

Adequate and timely personal care including oral and dental hygiene, care of senses, continence management, nutrition and hydration, and sleep hygiene was identified as an important feature of quality care. The importance of staff spending enough time with residents for feeding and washing, \textsuperscript{27} as well as providing personal care according to the resident’s preferences as best as possible was emphasised. \textsuperscript{12} Matters of personal comfort and care were also described \textsuperscript{30, 36} with residents’ quality of life notably influenced by any changes affecting the staff ability to meet personal care needs. \textsuperscript{30} Key personal care areas identified are:

1) Maintaining good oral and dental hygiene including cleaning of teeth and regular dental checks, which can impact on residents’ ability to eat and consequently their nutritional status; \textsuperscript{9, 11, 51}

2) Care of the senses involving adequate assessment of sensory loss, especially among residents with cognitive impairment, regular review of the fitting and use of hearing aids and spectacles as well as ensuring supportive environments (e.g. good lighting and clear hallways); \textsuperscript{9, 11, 12}

3) Quality continence management including establishment of toileting routines, provision of appropriate privacy and visual cues for toilet facilities; \textsuperscript{9, 11, 12}

4) Adequate hydration and nutrition including the assessment of food and water intake, malnutrition (weight loss) and dehydration and the provision of quality food and regular hydration, with adequate assistance during meal times for those in need; \textsuperscript{9, 14, 55} and

5) Quality sleep and establishing good sleep hygiene. \textsuperscript{9, 11, 12}
4. DISCUSSION
The provision of residential aged care in Australia encompasses a range of social, clinical, interpersonal and organisational dimensions. Underpinning all aged care provision is the ethos of person centred care, with a more recent emphasis on consumer directed care and reablement. Whilst broad-ranging in its application, person centred care is founded on providing a person with care that fits with their existing belief systems, preferences and cultural practices in a way that is meaningful and respectful to the person, regardless of their level of care needs and health conditions. At times person centred care may present a challenge for aged care homes who juggle individual preferences with delivery of care to numerous residents in a consistent way. In this review, we have presented findings predominantly from the research literature based on the residents’ and their families’ perceptions of residential aged care. Our focus has been on two questions: (1) What are the key drivers for choice of a residential aged care home in terms of quality of care and services?; and (2) What are the key domains that capture the consumer experiences of care and quality of services in residential aged care homes?

4.1. DRIVERS FOR CHOICE OF RESIDENTIAL AGED CARE HOMES
In addressing the first question we have included five research articles and two organisational reports. The limited research in this area suggest a fruitful field for further investigation. More importantly, it also suggests that the drivers for choice of a RACH can be difficult to elicit from consumers’ perspectives as they may have limited insights into what it is they can expect from a care environment that they do not wish to reside in.
Research has shown that one of the greatest fears among frail older people requiring care and assistance in the community is the prospect of entering a RACH.\textsuperscript{26}\textsuperscript{56} For many prospective residents and their families the decision to enter a RACH is not necessarily made over a long period of time nor researched thoroughly in advance, as their decision is usually left until the last minute, triggered by the person’s deteriorating health, described as a crisis management or a last resort.\textsuperscript{56} The domains identified here – physical environment, location, maintaining identity, keeping independence, maintaining continuity, staff capability and care with respect and dignity, availability of care and health services, and trusting management – reflect the importance of the person being able to retain a sense of their pre-admission self and developing good relationships between residents, families and staff/management as crucial for supporting successful transition to residential care. The importance of these interpersonal and social factors to decision-making was emphasised in the ACRCA checklist which noted “No checklist however can capture your natural instincts of how a facility makes you feel.”\textsuperscript{15} Whilst the list of eight domains for Question 1 overlaps with those of Question 2 (see Figure 2. Concept map of the key domains), it is noteworthy that the depth and breadth of the domains for Question 1 are quite limited in comparison. It may be the case that many potential residents and their families have limited experience of RACH prior to identifying the need for their admission so may be unsure of which factors to consider in advance.
4.2. QUALITY OF RESIDENTIAL AGED CARE HOME

The second of our questions had been more thoroughly researched with 43 research articles and four reports included. Reflecting the complexity of the residential aged care experience, the majority of studies focused on few aspects of care such as activity provision, use of physical spaces, nutrition or staff interactions. Residents and families focused on social and interpersonal aspects rather than technical aspects of clinical care with good care not just being care of the person physically but also care that considers social and emotional needs. The importance of facilities welcoming family members’ involvement in activities and the availability of communal spaces for family interaction was a prominent feature of a number of studies. Particularly for dementia care, there was an expectation that a RACH would do more than just tolerate family but instead support the resident to maintain a connection with their family.

Some similarities are observed in terms of the frequencies of the domains identified when the grey and academic literatures are combined. As shown in Table 1, the most commonly identified domain was Choice (preferences and autonomy and individualised, culturally sensitive care). Five other domains were also widely identified, although with more variation in the frequency of recognition of component elements. These domains and the most frequently identified elements were Respect and Dignity (personhood and autonomy, and personal belongings, privacy and confidentiality), Staff Actions and Interactions (communications and relationship building, partnership with family), Physical Environment (safe and secure, and cleanliness, hygiene, odour), and Social Environment (Meaningful, leisure activities, Social interaction opportunities). The remaining two
domains were less widely recognised in consumer perspectives: they were Organisational Environment and Resources (adequate staffing and stability, and access to allied health, GP and specialist services), and Clinical and Personal Care (hydration and nutrition).

Notably, contrary to our review findings about limited evidence of clinical and personal care aspects, a large proportion of complaints made through the Aged Care Complaints Scheme relates to this Clinical and Personal Care domain. Of 8,888 individual issues identified during 2014-2015, the top ten complaint areas made were:

- Health and personal care (e.g. infections, infection control, infectious diseases, clinical care, continence management, behaviour management and personal hygiene) (28.8%);
- Consultation and communication (e.g. internal complaints process, information, family consultation and failing to advise enduring powers of attorney or guardians) (11.8%);
- Physical environment (e.g. issues associated with call bells, cleaning, equipment, safety and temperature (9.4%);
- Personnel (issues associated with number of staff and training/skills/qualifications (9.4 per cent); and
- Medication management (e.g. access and administration) (7.6%).

Other issues raised by consumers include Food and catering (6%), Financial (4%), Falls and falls prevention (4%), Abuse (3%), and Specified care and services (3%).

Two possible explanations can be offered for the predominance of health and personal care issues in this list, compared to the domains identified in our review that found limited exploration of clinical and personal care matters. Firstly, the perceived gravity of the problems that would warrant submission of a formal complaint, may have played a role in this phenomenon. In other words, consequences of poor clinical and personal care (e.g. death, hospitalisation, deterioration of health) are usually considered as far greater than consequences of not having choice, respectful care, or opportunities for social activities (e.g. feelings of powerlessness, loss of control, emotional pain, depression). Secondly, consumers may have limited understanding of clinical care delivery processes, and may be hesitant to advocate or intervene in matters they perceive they do not have expertise to critique or criticise. While the extant qualitative research on the experiences of consumers in residential aged care reveals limited accounts of clinical matters, this absence does not mean these areas are not important to quality.

The consistency of most of the domains found in both organisational reports and research articles, as well as in the aged care accreditation standards and the key issues of complaints made through the Aged Care Complaints Scheme, shows that indicators of quality used at an organisational level mostly resonate with the experiences of residents and their families in terms of their experience of aged care. The challenge, however, is to find a way of uncovering these experiences in a way that is accessible and relevant from the point of view of policy makers and service providers.

Whilst the grey literature combined with the research articles has provided us with a detailed list of quality domains, it needs to be noted that some factors received limited attention. For example, sexuality was found in only one grey literature report and none of the research articles. Sexuality is clearly an important part of an
individual’s identity and should be included in any assessment of identity maintenance following admission, especially given the primacy of choice, identity and independence in both the research and grey literatures.

4.3. IMPLICATIONS FOR THE DEVELOPMENT OF A CONSUMER EXPERIENCE REPORT

Some of the qualitative research papers included in this review have provided rich insights into various dimensions of the consumers’ experiences of residential aged care: use of complementary medicine,\textsuperscript{52} men’s experiences of RACH,\textsuperscript{22} the meaning of good life,\textsuperscript{22} and friendship in RACH,\textsuperscript{38} for instance. Such a focus, whilst enabling in-depth exploration of a specific feature, cannot reveal the intricacies of resident experience that incorporates a multitude of factors (domains) throughout a single day or over a period of time. Therefore, the use of qualitative methods to comprehensively explore quality of care and quality of life, guided by tactfully designed relevant questions and prompts, is recommended to capture overall quality. Furthermore, we need to be cognisant of the importance of purposeful sampling (maximum variation sampling, e.g. people with dementia vs without, male vs. female, high vs. low level of dependency/care needs, CALD vs. non-CALD, etc.), and the need to include families/significant others, as well as residents in the Consumer Experience Report.
5. CONCLUSION

The landscape of aged care is changing rapidly, as are consumer expectations of what aged care has to offer, how it is offered and by whom. Terms such as ‘quality care’, ‘quality of life’, ‘quality staff’, and ‘quality of care home’ are at the forefront of almost every government, industry and consumer organisation policy documents. There has been a growing concern about inadequacies of systems and processes for how such ‘quality’ is captured in a meaningful way to all stakeholders involved in aged care, especially from consumers’ perspectives. This Rapid Review, conducted for the Australian Aged Care Quality Agency, has identified and made recommendations for a set of quality domains for the residential aged care sector.

For drivers for choice of residential aged care home the following domains are recommended:

- Physical environment
- Location
- Maintaining identity
- Keeping independence
- Maintaining continuity
- Staff capability and care with respect and dignity
- Availability of care and health services at all times
- Trusting management

For key domains of quality for residential aged care home the following domains are recommended:

- Choice
- Respect and dignity
- Physical environment
- Social environment
- Functional environment
- Staff actions and interactions
- Organisational environment and resources
- Clinical and personal care

The review has also provided methodological considerations (sampling and question development for the CER) to facilitate more comprehensive ways of capturing quality of care and services from consumers’ perspectives.

This work is a first step towards developing meaningful processes to better understand consumers’ experiences of residential aged care and the implications of the consumer experiences in determining ‘quality’ of care and services for the consumers. It will in turn help staff, service providers and policy makers further improve ‘quality’.
## APPENDIX A: SUMMARY OF PAPERS SELECTED FOR THE REVIEW

<table>
<thead>
<tr>
<th>Ref. number</th>
<th>Authors and Publication year</th>
<th>Type</th>
<th>Consumer / Stakeholder input</th>
<th>Key Domains Identified (domain/subdomain numbers in the report)</th>
<th>Dementia specific</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>*Courtney et al. 2011</td>
<td>Research - Quality Assessment indicators</td>
<td>Consumer representative (n=1) Clinicians, managers, researchers (n=5)</td>
<td>Meaningful, leisure activities (3.2.4.2), communication and relationship building (3.2.6.1), partnership with family members (3.2.6.2), clinical care (3.2.8.2), personal care (3.2.8.3)</td>
<td>No</td>
</tr>
<tr>
<td>10</td>
<td>*Fethney et al. 2013</td>
<td>Research - Questionnaire, quantitative</td>
<td>Residents (n=391) Family caregivers (n=671)</td>
<td>Preferences, independence and autonomy (3.2.1.1), Preferences, independence and autonomy (3.2.1.1), welcoming and homelike (3.2.3.3), meaningful, leisure activities (3.2.4.2), communication and relationship building (3.2.6.1), assessment and care plan (3.2.8.1), personal care (3.2.8.3)</td>
<td>Yes</td>
</tr>
<tr>
<td>11</td>
<td>*Alzheimer's Australia 2007</td>
<td>Guidelines</td>
<td>Consumers Staff, industry experts</td>
<td>Preferences, independence and autonomy (3.2.1.1), individualised, culturally sensitive (3.2.1.2), respecting personhood (3.2.2.1), respect for personal belongings, privacy and confidentiality (3.2.2.3), welcoming and homelike (3.2.3.3), tailored programs (3.2.4.1), meaningful, leisure activities (3.2.4.2), mobility and physical exercise (3.2.5.2), communication and relationship building (3.2.6.1), partnership with family members (3.2.6.2), staffing, stability and skill-mix (3.2.7.1), information exchange system (3.2.7.2), staff education and development opportunities (3.2.7.3), access to allied health, GP, specialist and other services (3.2.7.4), feedback/complaints mechanisms (3.2.7.5), assessment and care plan (3.2.8.1), clinical care (3.2.8.2), personal care (3.2.8.3)</td>
<td>Yes</td>
</tr>
<tr>
<td>12</td>
<td>*Alzheimer's Australia 2007</td>
<td>Guidelines</td>
<td>Consumers Staff, industry experts</td>
<td>Preferences, independence and autonomy (3.2.1.1), individualised, culturally sensitive (3.2.1.2), respecting personhood (3.2.2.1), respect for personal belongings, privacy and confidentiality (3.2.2.3), welcoming and homelike (3.2.3.3), tailored programs (3.2.4.1), meaningful, leisure activities (3.2.4.2), mobility and physical exercise (3.2.5.2), communication and relationship building (3.2.6.1), partnership with family members (3.2.6.2), assessment and care plan (3.2.8.1), clinical care (3.2.8.2), personal care (3.2.8.3)</td>
<td>Yes</td>
</tr>
<tr>
<td>13</td>
<td>*National Aged Care Alliance 2014</td>
<td>Report</td>
<td>Consumers Service providers, unions, sector professionals</td>
<td>Preferences, independence and autonomy (3.2.1.1), respecting personhood (3.2.2.1), cleanliness, hygiene, smell (3.2.3.2), welcoming and homelike (3.2.3.3), assessment and care plan (3.2.8.1), clinical care (3.2.8.2), personal care (3.2.8.3)</td>
<td>No</td>
</tr>
<tr>
<td>14</td>
<td>*Aged Care Report Card 2016</td>
<td>Quality Rating Criteria</td>
<td>Consumers</td>
<td>Individualised, culturally sensitive (3.2.1.2), respecting personhood (3.2.2.1), supportive facilities and physical features that facilitate social interactions, links with community, and daily activities (3.2.3.1), cleanliness, hygiene, smell (3.2.3.2), welcoming and homelike (3.2.3.3), tailored programs (3.2.4.1), meaningful, leisure activities (3.2.4.2), partnership with family members (3.2.6.2), caring, friendly and responsive to the needs timely and adequately (3.2.6.3), staffing, stability and skill mix (3.2.7.1), access to allied health, GP, specialist and other services (3.2.7.4)</td>
<td>No</td>
</tr>
<tr>
<td>15</td>
<td>*Aged Care Report Card Australia 2016</td>
<td>Checklist</td>
<td>Consumers</td>
<td>Physical environment (3.1.1), maintaining identity (3.1.3), keeping independence (3.1.4), staff capability and care with respect and dignity (3.1.6), availability of care and health services at all times (3.1.7), trusting management (3.1.8)</td>
<td>No</td>
</tr>
<tr>
<td>16</td>
<td>*BUPA</td>
<td>Checklist</td>
<td>Non-identified</td>
<td>Physical environment (3.1.1), maintain identity (3.1.3), keeping independence (3.1.4), staff capability and care with respect and dignity (3.1.6)</td>
<td>No</td>
</tr>
<tr>
<td>17</td>
<td>Caldwell et al. 2014</td>
<td>Research – qualitative</td>
<td>Family caregivers (n=27)</td>
<td>Physical environment (3.1.1), location (3.1.2), maintaining identity (3.1.3), maintaining continuity (3.1.5), trusting management (3.1.8), individualised, culturally sensitive (3.2.1.2), cleanliness, hygiene, smell (3.2.3.2)</td>
<td>Yes</td>
</tr>
<tr>
<td>18</td>
<td>Cheek et al. 2007</td>
<td>Research – qualitative</td>
<td>Residents (n=33) Family caregivers (n=48)</td>
<td>Physical environment (3.1.1), location (3.1.2), maintaining continuity (3.1.5), staff capability and care with respect and dignity (3.1.6), availability of care and health services at all times (3.1.7), cleanliness, hygiene, smell (3.2.3.2), access to allied health, GP, specialist and other services (3.2.7.4)</td>
<td>No</td>
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<tr>
<td>19</td>
<td>Giles et al. 2007</td>
<td>Research – qualitative</td>
<td>Residents and older</td>
<td>Location (3.1.2)</td>
<td>No</td>
</tr>
<tr>
<td>Table Number</td>
<td>Study Title</td>
<td>Research Type</td>
<td>Sample Size</td>
<td>Key Findings</td>
<td></td>
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<tr>
<td>20</td>
<td>Yeboah et al. 2013</td>
<td>Research – qualitative</td>
<td>Residents (n=20)</td>
<td>Maintaining identity (3.1.3), individualised, culturally sensitive (3.2.1.2)</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Quine &amp; Morrell 2007</td>
<td>Research – qualitative</td>
<td>Older people in the community (n=8881)</td>
<td>Preferences, independence and autonomy (3.2.1.1), respecting personhood (3.2.2.1), respecting the need for being valued and feeling useful (3.2.2.2), respect for personal belongings, privacy and confidentiality (3.2.2.3), welcoming and homelike (3.2.3.3), keeping independence (3.1.4)</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Jilik et al. 2006</td>
<td>Research – qualitative</td>
<td>Residents (n=14)</td>
<td>Preferences, independence and autonomy (3.2.1.1), respecting personhood (3.2.2.1), respecting the need for being valued and feeling useful (3.2.2.2), respect for personal belongings, privacy and confidentiality (3.2.2.3), supportive facilities and physical features that facilitate social interactions, links with community, and daily activities (3.2.3.1), cleanliness, hygiene, smell (3.2.3.2), welcoming and homelike (3.2.3.3), tailored programs (3.2.4.1), meaningful, leisure activities (3.2.4.2), social interaction opportunities (3.2.4.3), mobility and physical exercise (3.2.5.2), staffing, stability and skill-mix (3.2.7.1), staff education and development opportunities (3.2.7.3), access to allied health, GP, specialist and other services (3.2.7.4)</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Mlile et al. 2016</td>
<td>Research – qualitative</td>
<td>Residents and older people in the community (n=15)</td>
<td>Preferences, independence and autonomy (3.2.1.1), individualised, culturally sensitive (3.2.1.2), respecting personhood (3.2.2.1), respecting the need for being valued and feeling useful (3.2.2.2), respect for personal belongings, privacy and confidentiality (3.2.2.3), supportive facilities and physical features that facilitate social interactions, links with community, and daily activities (3.2.3.1), cleanliness, hygiene, smell (3.2.3.2), welcoming and homelike (3.2.3.3), tailored programs (3.2.4.1), meaningful, leisure activities (3.2.4.2), social interaction opportunities (3.2.4.3), mobility and physical exercise (3.2.5.2), staffing, stability and skill-mix (3.2.7.1), staff education and development opportunities (3.2.7.3), access to allied health, GP, specialist and other services (3.2.7.4)</td>
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</tr>
<tr>
<td>24</td>
<td>Walker &amp; Paliadelis 2016</td>
<td>Research – qualitative</td>
<td>Residents (n=18)</td>
<td>Preferences, independence and autonomy (3.2.1.1), respect for personal belongings, privacy and confidentiality (3.2.2.3), social interaction opportunities (3.2.4.3), communication and relationship building (3.2.6.1), partnership with family members (3.2.6.2)</td>
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<tr>
<td>25</td>
<td>Minney et al. 2015</td>
<td>Research – qualitative</td>
<td>Residents (n=13)</td>
<td>Preferences, independence and autonomy (3.2.1.1), respecting the need for being valued and feeling useful (3.2.2.2), respect for personal belongings, privacy and confidentiality (3.2.2.3), supportive facilities and physical features that facilitate social interactions, links with community, and daily activities (3.2.3.1), cleanliness, hygiene, smell (3.2.3.2), welcoming and homelike (3.2.3.3), tailored programs (3.2.4.1), meaningful, leisure activities (3.2.4.2), social interaction opportunities (3.2.4.3), opportunities for rehabilitation/reablement (3.2.5.1), caring, friendly and responsive to the needs timely and adequately (3.2.6.3)</td>
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<tr>
<td>26</td>
<td>Chin &amp; Quine 2012</td>
<td>Research – qualitative</td>
<td>Residents (n=25)</td>
<td>Preferences, independence and autonomy (3.2.1.1), respect for personal belongings, privacy and confidentiality (3.2.2.3)</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>De Bellis 2010</td>
<td>Research – qualitative</td>
<td>Residents (n=3)</td>
<td>Preferences, independence and autonomy (3.2.1.1), respecting personhood (3.2.2.1), welcoming and homelike (3.2.3.3), caring, friendly and responsive to the needs timely and adequately (3.2.6.3), staffing, stability and skill-mix (3.2.7.1), personal care (3.2.8.3)</td>
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<tr>
<td>28</td>
<td>Wilkes et al. 2011</td>
<td>Research – qualitative</td>
<td>Residents, older people in the community (n=11) Family members (n=2) Pastoral care (n=18)</td>
<td>Preferences, independence and autonomy (3.2.1.1)</td>
<td></td>
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<tr>
<td>29</td>
<td>McVey et al. 2014</td>
<td>Research – qualitative</td>
<td>Residents (n=72), Family members (n=21) Staff (Managers n=7, Care assistants n=23)</td>
<td>Individualised, culturally sensitive (3.2.1.2), clinical care (3.2.8.2)</td>
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<tr>
<td>30</td>
<td>Boldy &amp; Horner 2008</td>
<td>Research – qualitative</td>
<td>Residents Staff (no sample size)</td>
<td>Respect for personal belongings, privacy and confidentiality (3.2.2.3), personal care (3.2.8.3)</td>
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<tr>
<td>31</td>
<td>Fleming et al. 2016</td>
<td>Research – quantitative</td>
<td>Residents (n=275)</td>
<td>Respect for personal belongings, privacy and confidentiality (3.2.2.3), supportive facilities and physical features that facilitate social interactions, links with community, and daily activities (3.2.3.1)</td>
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<tr>
<td>32</td>
<td>Chenoweth et al. 2015</td>
<td>Research – qualitative</td>
<td>Family members (n=73) Staff (Managers n=29, Nurses and care staff n=70)</td>
<td>Respect for personal belongings, privacy and confidentiality (3.2.2.3), supportive facilities and physical features that facilitate social interactions, links with community, and daily activities (3.2.3.1), caring, friendly and responsive to the needs timely and adequately (3.2.6.3), staffing, stability and skill mix (3.2.7.1), staff education and development opportunities (3.2.7.5)</td>
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<tr>
<td>33</td>
<td>Arendts et al. 2015</td>
<td>Research – qualitative</td>
<td>Residents (n=11), Family members (n=14) Staff (n=17)</td>
<td>Being consulted (3.2.2.4), partnership with family members (3.2.6.2)</td>
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<tr>
<td>34</td>
<td>Thomas et al. 2015</td>
<td>Research – qualitative</td>
<td>Residents (n=6)</td>
<td>Supportive facilities and physical features that facilitate social</td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Researchers</td>
<td>Research Design</td>
<td>Participants</td>
<td>Findings</td>
<td></td>
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<td>------</td>
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<td></td>
</tr>
<tr>
<td>2013</td>
<td>qualitative</td>
<td>Research - Questionnaire</td>
<td>Not applicable</td>
<td>Supportive facilities and physical features that facilitate social interactions, links with community, and daily activities (3.2.3.1), meaningful, leisure activities (3.2.4.2), social interaction opportunities (3.2.4.3)</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>Fleming &amp; Bennett</td>
<td>Research - mixed methods</td>
<td>Residents (n=1000) Advocacy groups, Aged Service Industry, academics, policy makers</td>
<td>Supportive facilities and physical features that facilitate social interactions, links with community, and daily activities (3.2.3.1), cleanliness, hygiene, smell (3.2.3.2), welcoming and homelike (3.2.3.3), meaningful, leisure activities (3.2.4.2), partnership with family members (3.2.6.2), caring, friendly and responsive to the needs timely and adequately (3.2.6.3), access to allied health, GP, specialist and other services (3.2.7.4), personal care (3.2.8.3)</td>
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<tr>
<td>2013</td>
<td>Etherton-Beer et al.</td>
<td>Research - mixed methods</td>
<td>Family members (n=331) Staff (n=356)</td>
<td>Welcoming and homelike (3.2.3.3), partnership with family members (3.2.6.2), caring, friendly and responsive to the needs timely and adequately (3.2.6.3)</td>
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</tr>
<tr>
<td>2015</td>
<td>Casey et al.</td>
<td>Research - qualitative</td>
<td>Residents (n=36)</td>
<td>Meaningful, leisure activities (3.2.4.2)</td>
<td>Yes</td>
</tr>
<tr>
<td>2015</td>
<td>Travers</td>
<td>Research - mixed methods</td>
<td>Residents (n=20)</td>
<td>Meaningful, leisure activities (3.2.4.2)</td>
<td>Yes</td>
</tr>
<tr>
<td>2015</td>
<td>Roberts et al.</td>
<td>Research - mixed methods</td>
<td>Residents (n=16) Family members (n=7) Staff (n=18)</td>
<td>Meaningful, leisure activities (3.2.4.2)</td>
<td>Yes</td>
</tr>
<tr>
<td>2011</td>
<td>Taylor et al.</td>
<td>Research - qualitative</td>
<td>Residents (n=15)</td>
<td>Mobility and physical exercise (3.2.5.2), clinical care (3.2.8.2)</td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>Bauer &amp; Nay</td>
<td>Research - qualitative</td>
<td>Family members (n=12)</td>
<td>Communication and relationship building (3.2.6.1), partnership with family members (3.2.6.2), staffing, stability and skill-mix (3.2.7.1), access to allied health, GP, specialist and other services (3.2.7.4)</td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>Tuckett</td>
<td>Research - qualitative</td>
<td>Staff (n=18)</td>
<td>Communication and relationship building (3.2.6.1)</td>
<td>Yes</td>
</tr>
<tr>
<td>2007</td>
<td>Kellett</td>
<td>Research - qualitative</td>
<td>Family members (n=14)</td>
<td>Partnership with family members (3.2.6.2), caring, friendly and responsive to the needs timely and adequately (3.2.6.3)</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>Irving</td>
<td>Research - quantitative</td>
<td>Family members (n=150)</td>
<td>Partnership with family members (3.2.6.2)</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>Stokoe et al.</td>
<td>Research - qualitative</td>
<td>Nurses (n=31) GPs (n=10)</td>
<td>Staffing, stability and skill-mix (3.2.7.1), information exchange system (3.2.7.2), access to allied health, GP, specialist and other services (3.2.7.4)</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>Georgiou, Marks et al.</td>
<td>Research - qualitative</td>
<td>Staff (n=47)</td>
<td>Information exchange system (3.2.7.2)</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>Georgiou, Tariq et al.</td>
<td>Research - quantitative</td>
<td>Staff (n=93) Clinical care providers (n=7)</td>
<td>Information exchange system (3.2.7.2)</td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>Gaskin et al.</td>
<td>Research - mixed methods</td>
<td>Staff (n=119)</td>
<td>Information exchange system (3.2.7.2)</td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>Zhang et al.</td>
<td>Research - qualitative</td>
<td>Staff (n=110)</td>
<td>Information exchange system (3.2.7.2)</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>Tham et al.</td>
<td>Research - quantitative</td>
<td>Residents (n=6) Staff (n=9) Dentists (n=5)</td>
<td>Staff education and development opportunities (3.2.7.3), access to allied health, GP, specialist and other services (3.2.7.4), assessment and care plan (3.2.8.1), personal care (3.2.8.3)</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>Rayner &amp; Bauer</td>
<td>Research - qualitative</td>
<td>Residents (n=26) Family members (n=5) Staff (n=27) Key informants (allied/health professionals n=13)</td>
<td>Access to allied health, GP, specialist and other services (3.2.7.4)</td>
<td></td>
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<td>2011</td>
<td>Reymond et al.</td>
<td>Research - quantitative</td>
<td>Family members (n=87) Staff (n=468)</td>
<td>Clinical care (3.2.8.2)</td>
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<tr>
<td>2011</td>
<td>Rowley &amp; Taylor</td>
<td>Research - qualitative</td>
<td>Family members (n=8) Staff (n=14)</td>
<td>Clinical care (3.2.8.2)</td>
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<tr>
<td>2014</td>
<td>Ullrich et al.</td>
<td>Research - qualitative</td>
<td>Staff (n=21)</td>
<td>Personal care (3.2.8.3)</td>
<td></td>
</tr>
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</table>

*Grey literature
APPENDIX B: SUMMARY OF TOOLS AND GUIDELINES

ResCareQA

The Residential Care Quality Assessment (ResCareQA) tool was derived from a consultative process with expert clinicians and industry representatives who identified numerous clinical care indicators for aged care that were then refined using a Delphi technique (including clinicians, managers, researchers and a consumer representative) to produce the ResCareQA tool. It contains 24 questions across four domains:

- **Resident Health** (Pressure ulcer rates, Skin integrity, Infections, Medication, Pain management, Cognitive status, Unplanned Hospital Visits),
- **Personal Care** (Toileting and continence, Hydration status, Activities of daily living, Dental Health, Care of the senses),
- **Resident Lifestyle** (Nutrition, Meaningful activity, Sleeping patterns, Communicating, Adaptation and behaviour patterns) and
- **Care Environment** (Restrains, Falls, Depression, Family involvement, Allied health, Medical visits, Multi-disciplinary case conferences).

It allows the easy calculation of 36 clinical indicators for an overall assessment of quality in the residential care setting. The tool is usually completed within 30 minutes.

Client Perception of Value

The Client Perception of Value (CPV) is a questionnaire tool that can be used for assessing residents’ and relatives’ level of satisfaction and perceptions of the quality of aged care service. It was developed as part of the quality improvement activities of a large, faith-based aged care provider in NSW, underpinned by the philosophy of person centre care. Two questionnaires were designed, one for residents (64 items) and the other for relatives (67 items). The questionnaires contained items relating to care and services that residents and relatives identified as of value to them. The items were grouped into nine domains or service areas: assessing and delivering care, welcome, spiritual life, meals, activities, facilities, cleaning, laundry, and overall satisfaction.

Quality Dementia Care Standards: A Guide to Practice for Managers in Residential Aged Care Facilities

This guide links the principles of good quality dementia care to the framework of the Aged Care Accreditation Standards and was created following consultation with care managers, staff and consumers. With an emphasis on flexibility to meet individual needs, it is intended as a practical check-list of things that will help staff manage facilities for people living with dementia whether they are mainstream residential care facilities or special units. It highlights four standards with sub-criteria:
- Health and Personal Care (Clinical Care, Specialised Nursing Care Needs, Other Health and Related Services, Medication Management, Pain Management, Palliative Care, Nutrition & Hydration, Skin Care, Continence Management, Behavioural Management, Mobility, Dexterity and Rehabilitation, Oral and Dental Care, Sensory Loss, Sleep).
- Physical Environment and Safety Systems (Living environment, Occupational Health and Safety (OHS), Fire, Security and Other Emergencies, Infection Control, Catering, Cleaning and Laundry Services).

**Quality Dementia Care: Practice in Residential Aged Care Facilities for all Staff**
This document is a companion document to the above ‘Quality Dementia Care: A Guide to Practice for Managers in Residential Aged Care Facilities’. It presents staff guidelines which provide all workers (nurses, care workers, activity/lifestyle staff, other care staff, domestic staff, kitchen staff, gardeners etc.) who provide care for older people living with dementia, with practical information to help them deliver best practice person centred care in a residential setting. These guidelines were derived from current best evidence, focus groups and discussions at the 2006 Dementia Care Consensus Conference. Ten areas of practice are identified: communication, spiritual and emotional wellbeing, social interaction and lifestyle, personal care, health care, the physical environment, behaviour, abuse, sexuality, and cultural needs.

**NACA Quality Indicators**
This report identifies quality indicators for residential aged care services. These indicators consolidate the discussions of the National Aged Care Alliance’s Quality Indicators Reference Group and the Alliance’s previous work on Quality of Care, and is informed by the outcomes of the then Department of Health and Ageing’s 2006 project 'Evaluation of the impact of accreditation on the delivery of quality care and quality of life in Australian Government subsidised residential aged care homes'. Additional resources provided by Alliance members were also collated and considered. Six domains were identified to guide the development of the quality indicators: Person centred interactions, Health and wellbeing, Engaging socially, Daily services, Physical environment and Organisational and governance.
Consumer Quality Rating Criteria

This website identifies quality rating criteria for use by consumers including prospective residents and their families. Based on consumer reviews and rating of residential aged care homes, seven quality criteria for residential aged care homes are evaluated: staff presence, nursing care, friendliness, quality of food, activities, cleanliness and management. Each consumer review includes a rating out of five for each criteria.

Choosing a Care Home: Care Home Checklist

Also based on consumer reviews and rating of residential aged care homes, this document is a decision-aid tool for prospective residents of a RACH. The checklist items cover a number of social and clinical aspects: staff presence, nursing care, friendliness, quality of food, activities, cleanliness and environment and management. Up to four facilities can be compared on the one form. It refers to the individual’s ‘natural instinct’ of how each facility feels as an important factor in decision-making.

Choosing a care home: A guide to finding your new home

This guide is also a decision-aid for prospective residents to use when touring potential residential aged care homes. It is founded on ‘person-first care being the cornerstone of quality aged care: “Being Person-First means that employees value and seek to know each resident well; understand their experience; anticipate their needs and support them to retain as much personal independence and dignity as possible. If a resident’s personal and care needs are being met in a caring and supportive environment we believe a genuine sense of wellbeing will follow”. This guide was developed by Bupa Aged Care in collaboration with the Alzheimer’s Australia Consumer Dementia Research Network. The guide identifies seven main components for decision-making: welcoming and inviting, atmosphere, engagement and activity, interactions, respecting the individual, getting around and the care home community. Sub categories are organised according to look, listen and feel. Up to three facilities can be compared on the one form.
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34. Thomas JE, O'Connell B, Gaskin CJ. Residents' perceptions and experiences of social interaction and participation in leisure activities in residential aged care. Contemp Nurse 2013;45(2):244-54.
56. Jacobson J, Gomersall JS, Campbell J, et al. Carers' experiences when the person for whom they have been caring enters a residential aged care facility permanently: a systematic review. JBI database of systematic reviews and implementation reports 2015;13(7):241-317.