Appellon Care-Rite study: The experience of residential aged care services for older people and staff

October 2023

Prepared for Sue Jauncey – Founder, CEO & Registered Psychologist - Appellon

Acknowledgements

Aged Care Research & Industry Innovation Australia (ARIIA) was funded by Appellon, to analyse responses to the Care-Rite survey. All data was collected and provided as de-identified data by Appellon and its reliability and validity has not been verified by ARIIA or Flinders University.

Appellon Care-Rite study: the experience of residential aged care services for older people and staff

Abstract

The quality of aged care services contributes to wellbeing outcomes for older people. The new Australian Aged Care Quality Standards require providers to promote the emotional, spiritual, and psychological wellbeing of consumers in addition to clinical care outcomes. Clear measures are needed to demonstrate how providers achieve wellbeing outcomes. The perspectives of older people and their families about the care they receive, offer useful insights into how wellbeing outcomes can be achieved and how aged care staff can contribute to wellbeing outcomes.

This study identifies trends and relationships in the responses to the Appellon Care-Rite survey tool from the perspectives of older people, family representatives and staff. This snapshot of the three perspectives was undertaken in five rural and one metropolitan aged care home and shows the importance of social connections, and staff time to support the wellbeing of older people in residential aged care. Use of the Care-Rite survey tool has offered insights into how staff can support wellbeing in ways that matter to older people.

1. Background

The quality of care provided to older people accessing aged care services is an issue of great importance, globally and in Australia (1). To ensure appropriate quality of care the Australian government recently introduced a range of practical measures to improve the accountability and transparency in the aged care sector, by enacting the Aged Care and Other Legislation Amendment (Royal Commission Response) Act 2022. In introducing new standards, the Australian government clearly acknowledges the relationship between care processes and wellbeing outcomes for older people (1). Apart from requiring choice and dignity in the provision of personal and clinical care, providers are also expected to promote the emotional, spiritual, and psychological wellbeing of consumers (Standard 4) (2). This requires providers to consider the whole person, and the relationships older people have with aged care staff (1) that impact their wellbeing. While aged care providers have previously offered a range of general social and activity programs in residential aged care homes, the new standards require a clear focus on personalised and meaningful activities that support the individual's mental, emotional, spiritual, and psychological wellbeing. Quality of life measures have been identified as more useful than health indicators alone for reporting wellbeing outcomes (3). Hence providers are now required to report on indicators

of quality of life and consumer experience to monitor the wellbeing outcomes of care for older people (4). The use of two new measures, Quality of Life Aged Care Consumers (QOL-ACC) (5) and Quality of Experience Aged Care consumers (6) aim to report on and value the quality of life and the experience of aged care for older people. These tools reflect the importance of person-centred care and older people's experience in determining the quality of aged care in Australia (1). However, with the introduction of these tools in Australia in 2023, the impact of measuring quality of life and care experience (7) across aged care is not yet known and providers are exploring how best to capture and report this data quarterly as mandated in standards.

Investigation is also needed to understand how aged care staff can promote wellbeing across the key social, emotional, psychological, spiritual, physical and health domains for residents of aged care (8). The impact of the behaviour of care staff is particularly important for people with dementia, who comprise over half of people living in residential aged care (9).In particular, the way staff relate to and interact with older people affects their mood, function and food intake (10). Studies of older people's experience and evaluation of the care they receive (11), can be useful in measuring and informing improvements in quality of care. The perspectives of staff, combined with the evaluations of older people and family members of the wellbeing support they receive, can provide insight into how the service provider delivers care to meet the emotional, spiritual, and psychological needs of residents. (11).

Appellon (12), a private aged care workforce consultant, contracted Aged Care Research and Industry Innovation (ARIIA) (13) to analyse retrospective survey data from the Care-Rite survey, to explore links between perceptions of older people who are living in residential aged care and family satisfaction with wellbeing supports and aged care staff responses on how they provide those supports. The Care-Rite survey was developed by Appellon to assess how well social connections and the psychological, emotional, and spiritual needs of people living in aged care residential facilities were respected and met; the assessment of family members about the wellbeing of their relative in care; and staff perceptions about how they support the social connections, psychological, emotional, and spiritual wellbeing of residents.

This study explores the responses to the Care-Rite survey, by older people, their family and the staff providing care, to identify opportunities to improve the delivery of services that support better wellbeing outcomes.

2. Aims and objectives.

This study analysed the responses to the online assessment tool, Care-Rite to:

2.1 Assess if older people living in residential aged care and their families report that their social, psychological, emotional, and spiritual wellbeing needs are being met,

2.2 Assess if staff believe they are meeting the psychological, emotional, and spiritual needs of residents when delivering care,

2.3 Compare the responses of residents and family representatives with staff reports,

2.4 Identify opportunities to improve social, emotional, and psychological wellbeing of people in residential aged care.

3. Ethical approval

Approval for this study was granted by the Human Research Ethics Committee (Low Risk) of Flinders University on 19 May 2023 (HEL6115-3).

4. Methods

4.1 Care-Rite survey

Fifteen questions were asked in the Care-Rite survey of older people and family representatives, and four are relevant to the perceptions of the older person and their family members in relation to social connection and emotional, spiritual, and psychological wellbeing and have been included in this analysis (see Table 1).

Table 1. Questions of residents and family included in analysis.

Resident Q.3:	Have your spiritual, emotional, and psychological care choices been identified and met?	Response: 1= strongly disagree 2= disagree 3= neither agree nor disagree 4= agree 5= strongly agree
Representative Q.3:	I believe that (person in care) spiritual, emotional, and psychological care choices have been identified and met	Response: 1= strongly disagree 2= disagree 3= neither agree nor disagree 4= agree 5= strongly agree
Resident Q.4:	Do you feel a sense of calm, peace, contentment, meaning, purpose, or connectedness based on the care you receive?	Response: 1= strongly disagree 2= disagree 3= neither agree nor disagree 4= agree 5= strongly agree Not in this analysis
Representative Q.4:	I believe (person in care) feels a sense of peace,	Response: 1= strongly disagree

	calm, contentment, meaning, purpose, or connectedness based on the care received.	2= disagree 3= neither agree nor disagree 4= agree 5= strongly agree Not in this analysis
Resident Q 5:	Can you provide an example of the care and support you receive that supports your spiritual, psychological, and emotional wellbeing	Text response of examples
Representative Q.5:	Can you provide an example of the care and support received that supports (person in care)'s spiritual, emotional, and psychological wellbeing?	Text response of examples
Resident Q.6:	Is there anything else that we could do that would add to your spiritual emotional and psychological wellbeing?	Text response of other needs
Representative Q.6:	Is there anything we could do that would add to (person in care)'s psychological, emotional, and spiritual well-being?	Text response of other needs

The staff version of the Care-Rite survey included fourteen questions and five were relevant to social connection and emotional, spiritual, and psychological wellbeing for comparison with the responses of older people and their family. Table 2 provides the questions and the type of responses available to each question included in the analysis.

Table 2. Questions of staff included in analysis

Staff Q. 9:	Are the strategies and processes that support psychological, emotional, and spiritual well-being accessible to everyone who has direct contact with residents/clients?	Response: Yes/ No
Staff Q. 10:	What types of strategies or processes do you think can achieve *better relationships and connectedness* with older people?	Text responses:
Staff Q. 11:	Psychological, emotional, and spiritual wellbeing goals	Response: Yes/ No

	are incorporated into our overall care plans.	
Staff Q. 13:	Is the training aimed to enhance the psychological, emotional, and spiritual well-being of all residents and clients made available to all those who have direct contact with older people, regardless of whether they are employees, volunteers or contracted through another organisation?	Response: Yes/ No
Staff Q. 14:	Please provide an example of how the organisation delivers on the psychological, emotional, and spiritual well-being of residents and clients	Text responses

4.2 Data Collection

The retrospective Care-Rite data provided by Appellon for this study was collected from residents, family representatives and staff at six residential care homes in March 2023. All aged care homes were operated by one provider, with three in regional areas of Queensland, one in metropolitan Sydney and two in regional areas in New South Wales. All respondents/participants completed the survey once over a period of one month.

The survey was completed online by people living in residential aged care homes with assistance by staff or family members to access the survey and internet. Family representatives reported their perspectives when the resident was unable or unwilling to respond themselves, and staff working in those homes reported their impression of how they delivered emotional, psychological, and spiritual support and social connections as part of their daily work with residents.

4.3 Data Management

The data provided for analysis was anonymous, extracted by Appellon to Excel spread sheets and electronically transferred to ARIIA. Additional data on number of residents per home and total numbers of staff across the six homes was provided by Appellon.

Residents and families rated their agreement with statements about social connections and the provision of emotional, spiritual, and psychological support with scores on Likert scales from 1 (strongly disagree) to 5 (strongly agree). There were opportunities for text responses to provide examples and to suggest what could be improved. Survey questions for staff were more frequently limited to one option or a Yes/ No answer, but there was an opportunity for

text responses by staff to provide examples of what was provided in the home and the strategies that could be used to improve support for residents.

4.4 Analysis

Descriptive statistics were used to report the number of responses including percentages of residents per residential home and numbers of family and staff responses from each home. Modes of the responses on Likert scales were used to compare resident and family representative responses overall and between residential homes.

Ordinal measures used in Likert scales are not assumed to be intervals, so responses were not able to be statistically tested for significance.

Qualitative methods using text responses in survey tools were used to report examples of wellbeing support provided by residents and family representatives. Examples provided by staff were used to report on strategies used or needed for wellbeing support.

5. Results:

5.1 Overall Results:

In total, 132 residents, 68 family representatives, and 180 staff responses, across six residential aged care homes, were available for analysis. Figure 1 shows the number of responses per group and per care home.
There was considerable variation in the number of responses across facilities and between groups.

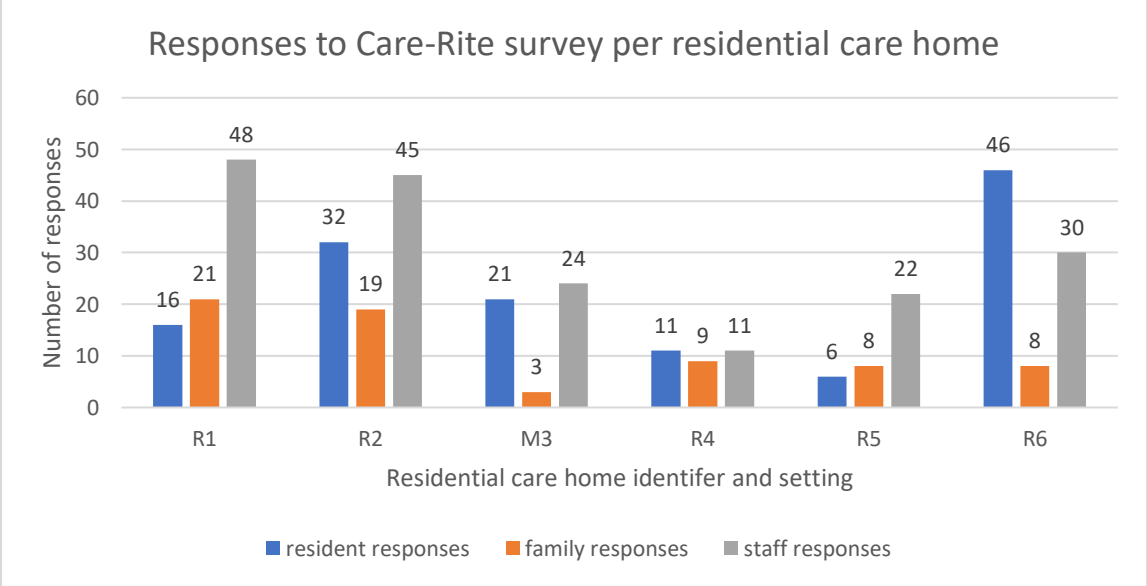

Figure 1. Responses to Care-Rite survey per residential care home by residents, family, and staff

5.2 Description of homes – unidentifiable

The six residential care homes have been designated R for regional and rural settings or M for metropolitan settings and the number of residents for each home and response rate (overall 31%) is provided in Table 3.
The numbers of family representative and staff per care home were not available for analysis.

Table 3. Settings, number of residents in each home and percentage of Care-Rite survey responses.

Home	No. of Residents	Number (%) of resident responses
R 1.	88	16 (18%)
R 2.	80	32 (40%)
M 3.	52	21 (40%)
R 4.	40	11 (27%)
R 5.	78	6 (8%)
R 6.	88	47 (53%)
Total homes = 6	Total residents = 426	132 (31%)

5.3 Resident responses:

Most residents who responded to Question 3 across all homes (77%), agreed, or strongly agreed that their spiritual, emotional, and psychological choices were identified and met. There were 17 (13%) uncertain responses, and only 13 residents (10%), in 2 facilities reported their choices were not identified or met (see Figure 2.)

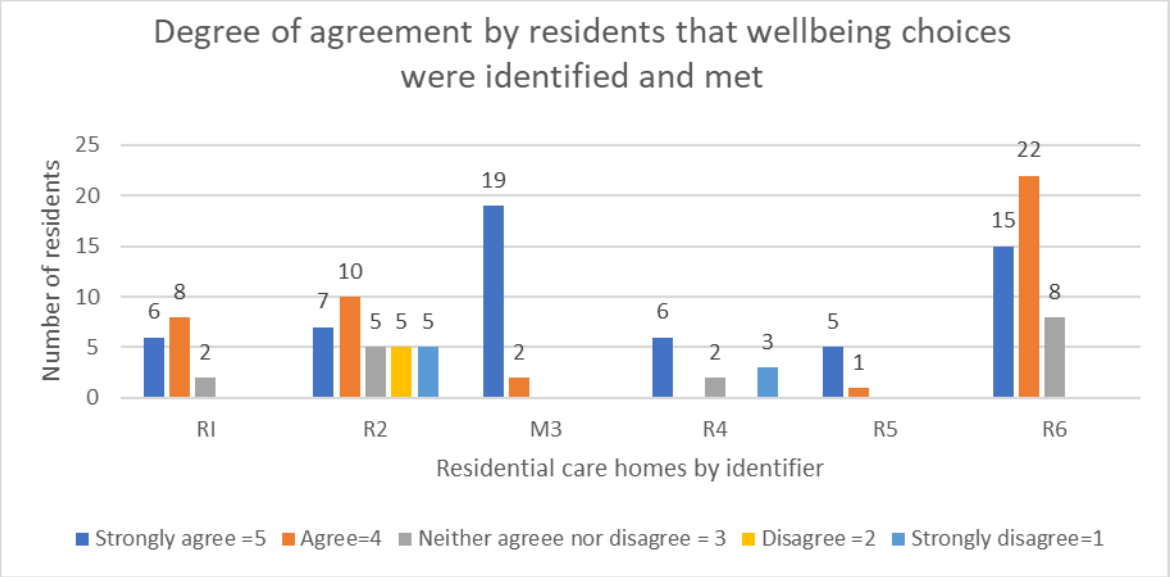

Figure 2. Degree of agreement by residents that their wellbeing choices are being met

While the most common rating of agreement by residents was 5, (strongly agreed), that spiritual, emotional, and psychological choices were identified and met, responses varied a little within each aged care home. Figure 2 shows resident responses in two aged care homes (R2 and R4) had most variations, while residents in two others (M3 and R5) had few variations. The question incorporated two elements of action (identified and met) and several aspects of wellbeing (psychological, spiritual, and emotional) so the text responses in Questions 4 and 6 add some further insights (see Table 5).

Percentages of residents' ratings were used to compare responses across the six residential care homes. Figure 3 shows the percentage of resident agreement with statements that wellbeing choices were met in each residential home. Over 50% of residents in all six homes reported they agreed or strongly agreed that their wellbeing choices were met. In two homes, however there were approximately 30% of residents who disagreed or strongly disagreed that their wellbeing choices were met.

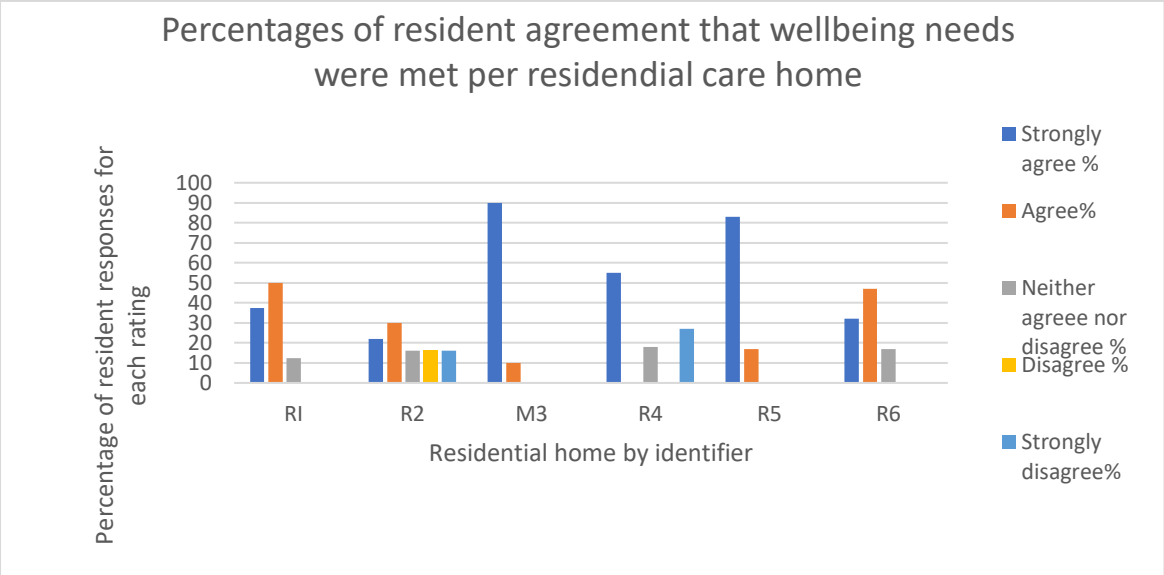

Figure 3. Percentage of resident responses for ratings on the degree that their wellbeing needs were met.

The most common responses (modes) to Question 3, were used to compare responses of residents and family representatives in each home (see Table 4). In most care homes there was agreement between the two groups that choices were identified and met.

Table 4. Modes of responses to Question 3.on whether spiritual, psychological and emotional choices were identified and met in each care home

Residential Care Home	Q.3 Resident agreement that choices were identified and met (mode)	Q.3 Family agreement that choices were identified and met (mode)
R1	4= agreed	5=strongly agreed
R2	4=agreed	4=agreed
M3	5=strongly agreed	5= strongly agreed
R4	5=strongly agreed	4=agreed
R5	5=strongly agreed	5=strongly agreed
R6	4=agreed	3= neither agreed nor disagreed
Overall Mode	5= strongly agreed	5= strongly agreed

Most residents who responded (76%) reported agreement or strong agreement that they felt a sense of peace, contentment, meaning, purpose, and connectedness based on the care they received. Only 11 (8%) residents across all homes disagreed or strongly disagreed with this statement.

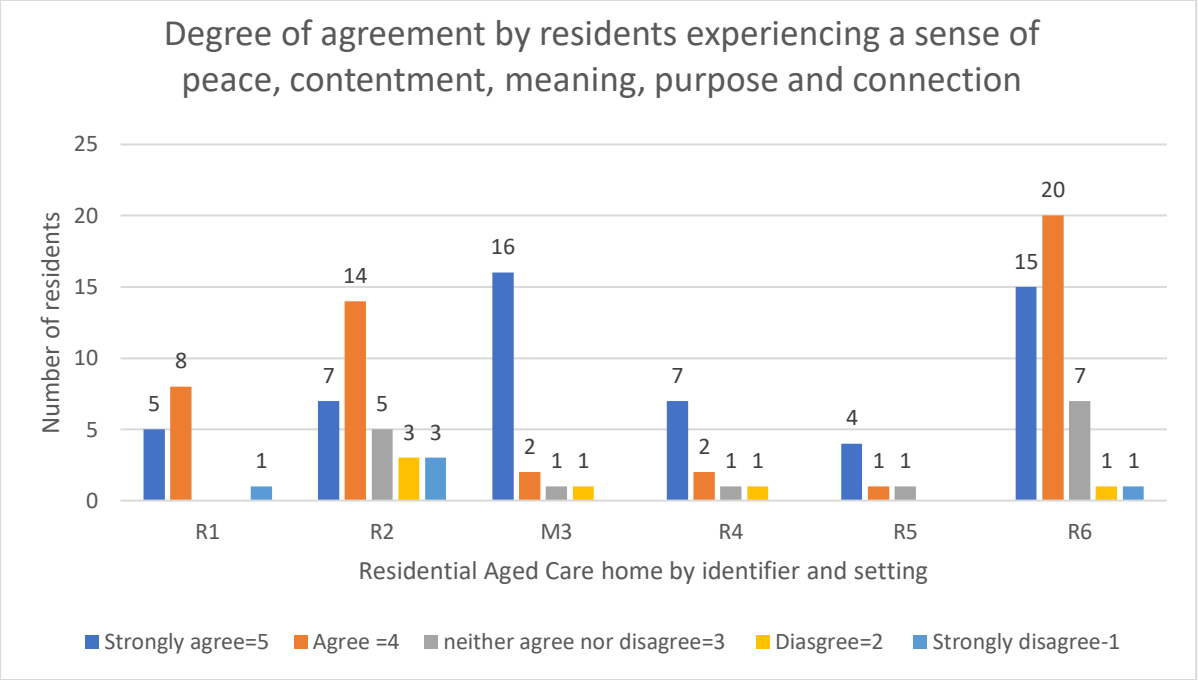

Figure 4. Degree of agreement by residents experiencing a sense of peace, contentment, meaning, purpose, and connection.

Percentages of residents' ratings were used to compare responses across the six residential care homes. Figure 5 shows the percentage of resident agreement with statements that residents felt a sense of contentment and connection in each residential home. Over 66% of residents in all six homes reported they agreed or strongly agreed that the felt a sense of contentment and connection. However, in one home, 18% of residents disagreed or strongly disagreed with this statement.

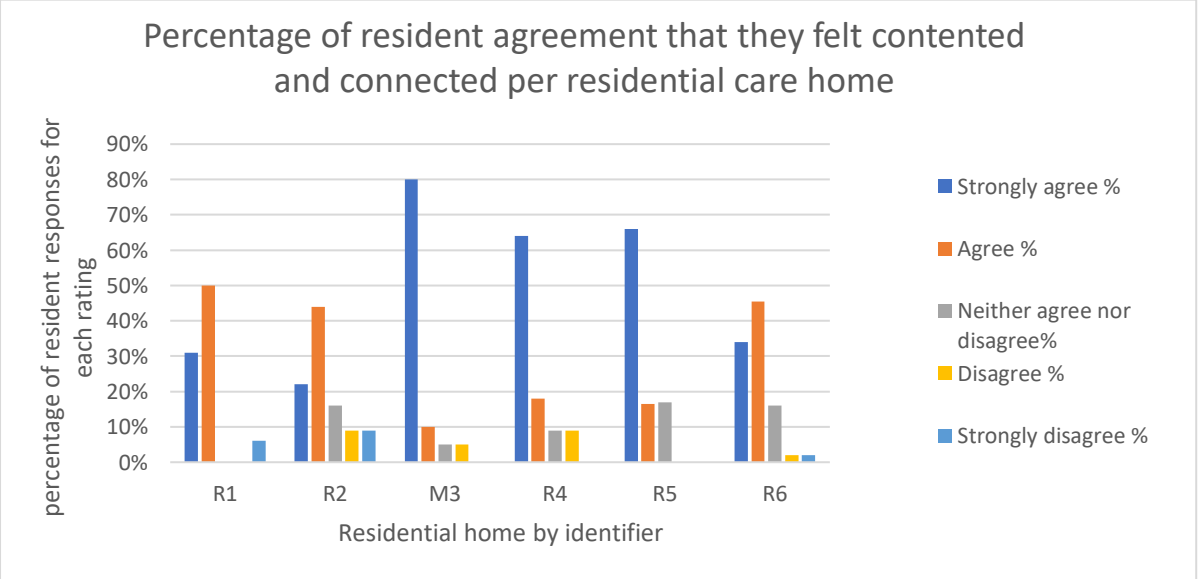

Figure 5. Percentage of resident responses for ratings on the degree of peace, contentment, meaning, purpose, and connection they experienced

Four qualitative themes were identified from resident responses to:

Question 5.: “Can you provide an example of the care and support you receive that supports your spiritual, psychological, and emotional wellbeing” and

Question 6.: “Is there anything else that we could do that would add to your spiritual emotional and psychological wellbeing?”

Theme 1. Care was there when needed.

Most residents reported that care from staff was available when they needed it, both practical assistance and emotional support. Some residents were concerned about the lack of time for staff to provide the support needed.

Theme 2. Family and community provide support.

Residents relied on family and friends for support and outings. Being able to maintain relationships with spouses and friends from the community was valued highly to meet spiritual, psychological, and emotional needs. Where another community contact or spouse resided in the facility there was a sense of connection and support for the resident.

Theme 3. Religious faith activities provide support.

Approximately half of resident responses (49%) identified choice of and connection to religious services and chaplains provided support. For a resident with no religious beliefs, staff provided emotional support through talks and activities.

Theme 4. Opportunities to talk with staff were valued.

Residents reported that the opportunities to chat with staff were important to them and gave examples of when staff provided emotional support.

Table 5. Examples provided by residents of support needs met.

Examples provided by residents of the care to support psychological, emotional, and spiritual wellbeing.			
Positive about care and support from staff	“I am listened to, and carers are approachable”	“I receive support by staff sitting with me and explaining what I don’t understand. Lifestyle staff and the Chaplain visit regularly”	“People are kind, they listen, all of them working here is kind and contribute to life here in the place”
Positive about spiritual support	“Two staff in Leisure and Lifestyle Team that help me always with emotional moods I am not a spiritual person”	“I chose to go the Anglican Church service and staff always come and take me”	“Good ministry teams, I enjoy the Salvation Army, and Anglican services”
	“Facility Chaplin is always there if I need him. Enjoy his church services and bible studies”	“The opportunity to attend church service”	

Positive about family and community support	"Very good, a friend here in same facility to share with them"	"Family support me very well"	"If I am upset, I have a phone I can call my wife. Staff set a table up for me if I want to have a meal with my wife"
	"I have many people I can talk to and give me support when I need it."	"My husband lives in the room next to me as well"	
Positive examples of personalised events	"It was my 93 birthday this month and I have had the best birthday ever"	"I have been supported with a facility to continue my passion with woodworking"	
Negative/ not fully supported	"Staff do the best that they can"	"I do feel supported but there are some outstanding concerns"	"Sometimes, care staff do not have time".

While many residents reported that the choice of church services or chaplain visits met their spiritual needs, others found emotional support through family and friends, with some identifying that the staff offered emotional support. Few residents reported dissatisfaction with the support for spiritual, emotional, and psychological choices. Lower ratings were identified in two homes. These related to their needs not being met to help them get through the day, being upset by intrusive residents, and a lack of time for staff to attend to them when needed.

In general, residents wanted more support such as assistance with exercise, more night staff, same carers being assigned to them for continuity and staff doing something about intrusive residents. These examples suggest that positive support at times of vulnerability is important to residents.

6.4 Family/Representative responses

There were 69 responses from family representatives across six residential aged care homes. While the total number of family representatives is not known, this number of responses is likely to represent 16% of the older people living in the six residential care homes.

Over half (62%) of family representatives agreed or strongly agreed that their relatives' spiritual, emotional, and psychological choices were identified and met. There were 13% of responses that strongly disagreed or disagreed that residents' choices were met, with a group (23%) who provided uncertain responses.

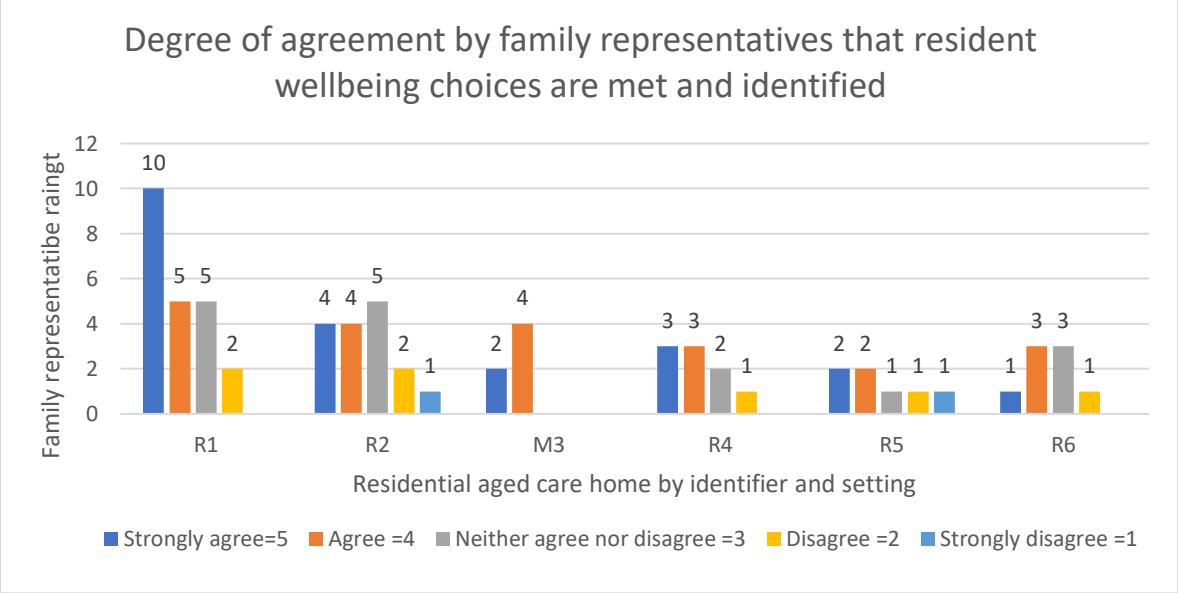

Figure 6. Degree of agreement by family representatives that residents emotional, spiritual, and psychological choices are identified and met.

Similarly, 58% of family representatives agreed or strongly agreed that their family member felt peaceful, contented, and connected and had meaning and purpose. There were 14% of responses that disagreed or strongly disagreed that residents felt a sense of peace, contentment and connection and a larger group (28%) of family representatives who were uncertain about how their family member felt.

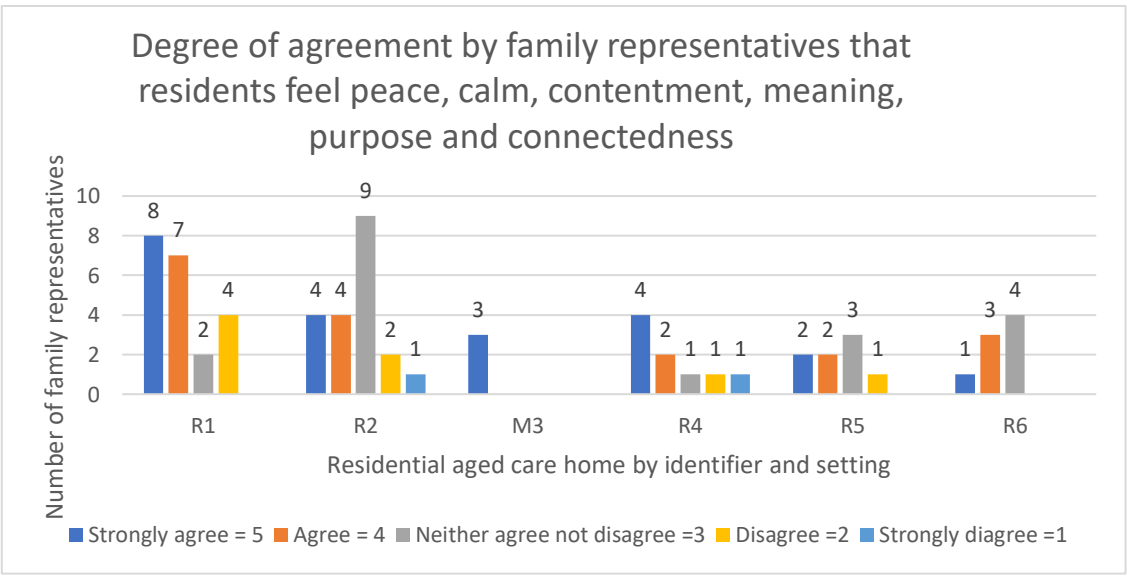

Figure 7. Degree of agreement by family representatives that residents feel a sense of peace, contentment, meaning, purpose, and connection.

Table 6. shows the comparison of most common responses (mode) to Question 4 by residents and family representatives. In most care homes there was a difference in ratings between residents and family representatives.

Table 6. Modes of responses to Q.4 on whether residents and family representatives agreed their relative felt a sense of peace, calm, contentment, meaning, purpose, and connection in each care home.

Three qualitative themes were identified from family representatives' responses to Q.5 and 6.

Theme 1. Support to attend religious activities:
Most agreed that spiritual, emotional, and psychological choices were met and provided examples of how religious activities were supportive and maintained valued faith rituals. For residents who did not value religious activities, family representatives offered examples of residents being involved in group experiences during the day as providing a sense of inclusion.

Theme 2. Emotional support and encouragement
Family representatives reported that emotional support offered by staff in times of distress were encouraging for their family member. In addition, family appreciated staff efforts to retain resident interests and support the transition process for new residents.

Theme 3. Negative comments
Only 10% of family representatives reported negative examples about the level of support provided. The examples included limited availability of staff to respond to call bells or to assist with toileting, which distressed residents. Some indicated the need for more one to one engagement by staff and understanding of individual resident desire to be involved in care decisions. They considered that staff turnover contributed to their lack of certainty about needs being met.

Residential Care Home	Q.4 Resident agreement that they felt a sense of peace, calm, contentment, meaning, purpose, and connection (mode)	Q.4 Family agreement that their relative felt a sense of peace, calm, contentment, meaning, purpose, and connection (mode)
R1	4= agreed	5=strongly agreed
R2	4=agreed	3= neither agreed nor disagreed
M3	5=strongly agreed	5= strongly agreed
R4	4= agreed	5= strongly agreed
R5	5=strongly agreed	3=neither agreed nor disagreed
R6	5= strongly agreed	3= neither agreed nor disagreed
Overall Mode	5= strongly agreed	5= strongly agreed

Table 6. Family representative examples of support for needs

Examples provided by family representatives of the care to support psychological, emotional, and spiritual wellbeing of their relatives.		
Positive about care and support from staff	"The staff have supported her & encouraged her to keep active, that she has a lot to live for."	"Very supportive of mums needs as she settles into this new environment".
	"Spending time and listening to her"	
Positive about Spiritual support	"Activities offered and mass each day if she wants to go".	"He is not interested in religion but generally feels included with group meal sessions"
	"Mum is encouraged to participate in church services as mum is a devoted Christian"	
Negative about support	"It hasn't and never will" in relation to meeting support needs	"Not sure that it has. She has only been there a short time and there have been a lot of staff changes during her time there"
	"He becomes frustrated at times as believes people don't always involve him in decision making."	"They move her to sit in different places, but the staff don't have time to spend with the residents. They usually sit alone in their courts. I try to go in daily to give Mum her lunch to help the staff".

6.5 Staff responses

In total 184 staff responded to the Care-Rite survey. The total number of staff across the six residential care homes was not available to calculate a response rate. Most of the questions in the staff version of the Care-Rite survey differed from those in the resident and family representative surveys. Most questions provided one option for the staff member to choose. This option reinforced messages about the processes provided for staff to support the needs of residents but were not suitable for analysis in this report. For Questions 9, 11, and 13, (see Table 7) staff were provided with a choice of a yes or no response about their access to strategies to support resident wellbeing, if these strategies were incorporated into care plans, and the availability of training for staff in supporting wellbeing and social connection. The majority (92%+) of staff responded yes to these questions (see Table 7).

Table 7. Percentage of Yes or No responses by staff to questions 9, 11 and 13 in Care-Rite survey

Question	Staff response	
Q.9 Are the strategies and processes that support psychological, emotional, and spiritual wellbeing accessible to everyone who has direct contact with residents/clients?	Yes: 170 (94%)	No: 10 (6%)

Q.11 Psychological, emotional, and spiritual wellbeing goals are incorporated into our overall care plans.	Yes: 166 (92%)	No: 14 (8%)
Q.13 Is the training aimed to enhance the psychological, emotional, and spiritual wellbeing of all residents and clients made available to all those who have direct contact with older people, regardless of whether they are employees, volunteers or contracted through another organisation?	Yes: 166 (92%)	No: 14 (8%)

Several staff in one residential care home identified gaps in available strategies, gaps in care plans and gaps in staff training. Only one person reported they were dissatisfied with the level of care provided at the facility.

Qualitative themes from staff survey responses.

For Question 10, (see Table 8) staff were offered the opportunity to provide text responses with examples of strategies they believed would achieve better relationships and connectedness with residents. Four themes were identified from their comments; communication, training for staff, person focus, and staff needs.

Table 8. Strategies suggested by staff to achieve better relationships and connectedness with residents,

Q.10 Examples of strategies that would achieve better relationships and connectedness with older people?			
Communication strategies	“Speaking English clearly”	“Listen, empathy, show kindness and understanding”	“Asking them what they would enjoy”
	“Keeping them informed/ up to date, let them know of changes”	“Always turn up with a smile on your face”	“Taking time to build trust”
Training for staff	“How to talk with older people”.	“Dementia training about complex behaviours/difficult residents”	
Person focussed	“Listening more and allowing residents to have input/ make decisions about care”	“More one to one time to get to know the resident to foster relationships”	“More attention to bed bound residents, hand massages, music, trip down memory lane”
	“Treat older people like we would want to be treated”	“Person centred approaches, better assessments to tailor care for residents”	“Forming groups for like-minded residents. Finding community contacts for resident who don’t have visitors”.

Staff related needs	"More time to spend getting to know residents"	"Screening of staff to ensure they are the right people in the job who want to care for older people"	"Continuity of staffing and more staff on duty to respond/ provide lifestyle activities"

These strategies concur with residents' responses of what they found were positive support for their wellbeing. Residents also identified the need for more staff and the importance of family and external community connections. Family representatives similarly appreciated staff spending one to one time with residents but were concerned about the continuity of staff and adequate staff to support residents who were less able to interact with others.

For Question 14 (see Table 9), staff were offered the opportunity to provide text responses of examples of how the residential aged care home provides psychological, emotional, and spiritual support. Most staff provided examples of what they or others did to support residents' spiritual, emotional and psychological wellbeing, with some identifying the difficulty in finding time to respond to all residents' needs. Three themes were identified: having positive activities, one-to-one interactions with residents and specific supports for distress or end of life. Examples where gaps were identified included concern over staff continuity and not having activities organised to suit the interests of residents.

Table 9. Examples from Staff on how the residential aged care home delivers wellbeing support

Q.14 Please provide an example of how the organisation delivers on the psychological, emotional, and spiritual wellbeing of residents and clients			
Positive activities	"By organising different activities like church service, knitting program, resident meeting"	"Staff went above and beyond to help celebrate the wedding anniversary of a resident and his wife"	"Putting residents first every day, smiling and happy staff keep residents happy"
One to one interaction	"Having 1/1 and having the appropriate service available"	"One on one time interaction of activities to accommodate physical and psychological stimulation"	"We have multi-disciplinary teams to engage with residents for their psychological, emotional, and spiritual wellbeing of residents. The clients can access the support system."
Specific supports at times of distress	"Support resident at the end of life. Facilitate fellow residents who	"The minster is always available to give support when a	

	have been lifelong friends to sit together, hold hands and farewell their friend at the end of life."	family or staff have a family member pass away"	
Gaps identified	"Our Lifestyle program is sorely lacking in organisation and care."	"Not enough staff to cope with huge work volumes and enormous amounts of paper (computer) work required"	"Care not being provided by a regular base of familiar people; a client was very upset that I had turned up and not a familiar face she was quite distraught"

Most responses were from staff providing care, with three from corporate services or managers who identified strategies used by care staff.

Direct care workers related the importance of one-to one time with residents and family case conferences as ways they provided person-centred care. They offered descriptions of showing care and compassion when residents were upset or dealing with health problems and how providing opportunities for residents to attend regular church services met spiritual needs. They believed the lifestyle activities were important for residents to feel comfortable in the facility and to engage in something interesting. The care worker roles were limited to talking with residents and having enough time to get to know them, with greater reliance on lifestyle and multidisciplinary teams to provide more support for spiritual, psychological, emotional support and social connection.

6.6 Comparison of responses

There was strong agreement between resident, family representatives and staff perspectives about what strategies provided support for wellbeing and a sense of peace or connectedness. A clear majority of resident and family responses showed strong or very strong agreement with statements about having their choices identified and met and feeling a sense of contentment and connectedness.

Table 10. Comparison of responses to survey questions by residents, family representatives and staff across six care homes

Questions	Resident response	Family member response	Staff response
Q.3 Agreement that choices were identified and met	77% agreed or strongly agreed	62% agreed or strongly agreed	

Q.4 Agreement that residents felt a sense of peace, calm, contentment, meaning, purpose, and connection	76% agreed or strongly agreed	58% agreed or strongly agreed (28% were uncertain)	
Q.9 Strategies and processes that support psychological, emotional, and spiritual wellbeing were accessible	Examples: religious services, one to one talks and walks		94% agreed
Q.11 Psychological, emotional, and spiritual wellbeing goals were incorporated into care plans	Examples: Support by staff when upset or family contact wanted, staff providing information, smiling		92% agreed
Q.13 Training aimed to enhance the psychological, emotional, and spiritual wellbeing of all residents was available	Examples: staff support to farewell residents who died, special events and for times of distress		92% agreed

Family representatives were a little more uncertain about whether wellbeing strategies and connectedness choices were met. This may be due to different expectations or less close or regular observations of care. Staff understood what strategies helped to meet wellbeing choices and a sense of contentment and connection and provided examples that clearly aligned with resident and family representative's perspectives. All respondents recognised the need for more time for staff to spend in one-to-one time with residents and the need for more staff to do this.

There were low levels of dissatisfaction with support from residents and families, and low levels of dissatisfaction by staff with the care provided in their setting.

While there was some variation between the responses across the six aged care homes in this analysis, the type of data did not allow statistical testing of significance of the variation.

7. Discussion

The Care-Rite survey provided opportunities for older people living in residential care homes, family representatives and staff members to provide their perspectives of the quality of care provided to support choices for social connections, spiritual, psychological, and emotional needs. This is particularly relevant to the increased focus by the Aged Care Quality and Safety Commission (4) on the quality of life and experience of older people living in residential aged care homes. While the introduction of validated measures of the quality of life (QOL-ACC) and quality of experience of consumers (QOL-ACC) in 2023 aims to provide public reporting in aged care, that reporting is not yet available. The Care-Rite survey

analysed in this report offers an example of how to seek perspectives on wellbeing and social connections aspects of quality of life and care experience for older people and their family representatives. The Care-Rite survey offers an additional insight into how staff can support wellbeing in ways that are valued by older people and their family representatives. Several of the themes identified in the analysis of Care-Rite data correspond to other surveys of quality of care or care experience. High rates of satisfaction, access to staff to talk to and the connection between how staff approach care, appear to be key concerns for older people and their family relatives. The recent discussion paper by the creator of the Care-Rite surveys (14) outlines the impact of the recent inquiry into quality and safety in aged care (15), excessive regulation on staff capacities to care and the importance of fostering hopefulness in the workforce. She argues that this is driven through a focus on what matters to residents, and psychological training for staff to support wellbeing.

While many examples of poor care were identified in the recent Royal Commission into Quality and Safety of Aged Care (16) most residents of residential aged care services provide positive views of their experience in aged care, with over 85% reporting feeling safe and having staff to explain things (17). While the levels of satisfaction reported in this Australian Institute of Health and Welfare (AIHW) study, compare favourably with the Care-Rite results, they report on different aspects of the experience of care. The AIHW survey focussed on issues related to safety, health care, food, if they thought the place was well run, as well as access to staff to talk to. Some of these issues relate more to satisfaction with care rather than wellbeing. A focus on satisfaction may best suit healthcare which is more short term and episodic. Long term care for older people needs to focus on person-centred experiences of care where valuing the person and their perspective in a social context are core elements (18). A recent study identified key components of older adults experiences of care and how they can promote wellbeing (11). The components of this care experience framework connect person-centred care with the care experience for older people to promote wellbeing. Where autonomy, dignity and unique needs are met, the authors argue older adults experience respect, empowerment, connection and engagement which in turn contribute to emotional wellbeing, a sense of value and worth, meaning and purpose (11). These connections between the care that is provided, how it is experienced, and how it contributes to wellbeing offer insight into how staff can support wellbeing in a way that matters to older people. This approach aligns with the Care-Rite survey which elicits residents' perspectives on their wellbeing and social connections and adds insight for staff about what matters in the way they approach care tasks for the older person.

In Australia the reliance on measuring clinical quality outcomes has been questioned because it can overlook the resident's perspective (19). Quality of life measures that are now

being introduced in new aged care standards reporting, focus on physical health, along with an assessment of mental and emotional health, social connections, spiritual connections of older people and the environment in which they live (19). The Care-Rite survey adds the opportunity to include the perspectives from residents and compare that with perspectives of family representatives and staff. In this way improvements can be identified, and staff can be supported to address wellbeing for older people.

There were several limitations in this study. It is a snapshot of six residential care homes survey data from one provider using Appelon's training and survey tools. It may not be generalisable to other services but demonstrates how seeking perspectives from residents, family representatives and staff can provide insights into the role of care staff in supporting wellbeing. It also offers information on areas where improvements are needed. The survey tool itself was used by 31% of residents and almost 40% of staff. It was not possible to identify what proportion of family representatives completed the survey. There may have been bias in the reporting due to self-selection by volunteer residents and family representatives to complete the survey and the exclusion of people with dementia. Some residents may have required support from relatives or staff to undertake the survey which could affect their responses. It was also not clear how much support was given to residents to complete the survey or how much time was needed for staff to provide the feedback. The survey tool could be simplified by ensuring that questions relate to a single concept to tease out what matters most to residents and family representatives. The questions involving multiple concepts may have been interpreted differently by respondents so may not provide reliable results. There is an opportunity to consider improvement in the wording of questions. The use of a conceptual framework such as that of Kabadayi and colleagues (11) may provide a guide to focussing questions. A comparison with the components of the quality-of-life tool being used in aged care reporting, may provide options to align Care-Rite with the domains covered in those tools. Similarly, by aligning the staff survey responses directly with the questions asked of residents would offer clearer comparisons between perspectives of staff strategies and the experience of residents.

8. Conclusion

The analysis of this snapshot of the perspectives of residents, family representatives, and staff regarding wellbeing indicates mostly positive experiences in residential aged care. These perspectives aligned with staff responses, identifying the key strategies that older people valued for their wellbeing. Residents and family members value most highly the relationships with care staff. These relationships offer opportunities to talk and get to know

each other in the regular and intimate routines of the day. Relationships enable person-centred care and contribute to residents' care experience of being respected and connected, promoting wellbeing (8). This report highlights how staff can contribute to social connections and wellbeing and the impact this has on the care experience for older people.

The insights provided by the analysis of the Care-Rite survey responses, offers the opportunity to consider areas for improvement. The major areas of dissatisfaction with wellbeing support related to staff availability, support for people with physical and cognitive decline, staff continuity and management of intrusive residents. These are areas of skill and confidence of staff and the way they undertake their roles. Continuity of staffing and additional time to get to know older people may improve staff satisfaction with their roles and an improved care experience for older people.

Further research on the perspectives of residents, family representatives and aged care staff is needed to determine how best to improve the quality and experience of residential aged care for older people.

Acknowledgements: We wish to acknowledge Apollo Care for their support and for facilitating residents, family members and staff use of the Care-Rite survey.

See Attachment A for a summary of results

References

1. Cleland J, Hutchinson C, Khadka J, Milte R, Ratcliffe J. What defines quality of care for older people in aged care? A comprehensive literature review. Geriatrics & Gerontology International. 2021;21(9):765-78.

2. Australian Government. Aged Care Quality and Safety Commission Canberra: Commonwealth of Australia; 2023 [Aged Care quality standards]. Available from: https://www.agedcarequality.gov.au/about-us.

3. Siette J, Dodds L, Surian D, Prgomet M, Dunn A, Westbrook J. Social interactions and quality of life of residents in aged care facilities: A multi-methods study. PLOS ONE. 2022;17(8):e0273412.

4. Aged Care Quality and Safety Commission. National Aged Care Quality Indicator program Canberra: Australian Government; 2023 [cited 2023. Available from: https://www.agedcarequality.gov.au/providers/national-aged-care-mandatory-quality-indicator-program.

5. Ratcliffe J, Bourke S, Li J, Mulhern B, Hutchinson C, Khadka J, et al. Valuing the Quality-of-Life Aged Care Consumers (QOL-ACC) Instrument for Quality Assessment and Economic Evaluation. PharmacoEconomics. 2022;40(11):1069-79.

6. Chen G, Ratcliffe J, Milte R, Khadka J, Kaambwa B. Quality of care experience in aged care: An Australia-Wide discrete choice experiment to elicit preference weights. Social Science & Medicine. 2021;289:114440.

7. Gilbert AS, Garratt SM, Kosowicz L, Ostaszkiewicz J, Dow B. Aged Care Residents' Perspectives on Quality of Care in Care Homes: A Systematic Review of Qualitative Evidence. Research on Aging. 2021;43(7-8):294-310.

8. Taylor S, Walton R, Martini A. Health, well-being and quality of life in aged care: Validation of theoretical domains to inform a person-centred outcomes measurement framework. Australasian Journal on Ageing. 2023;42(1):9-19.

9. Anderson K, Blair A. What have staff got to do with it? Untangling complex relationships between residential aged care staff, the quality of care they provide, and the quality of life of people with dementia. Archives of Gerontology and Geriatrics. 2021;94:104378.

10. Anderson K, Bird M, Macpherson S, Blair A. How do staff influence the quality of long-term dementia care and the lives of residents? A systematic review of the evidence. International Psychogeriatrics. 2016;28(8):1263-81.

11. Kabadayi Sertan HK, Lee Yuna HL, Walsman Matthew, Dobrzykowski David. Fostering older adult care experiences to maximize well-being outcomes. Journal of Service Management. 2020;31(5):953-77.

12. Appellon. Appellon Perth: Appellon; 2023 [Available from: https://www.appellon.com/#about.

13. Aged Care Research Industry and Innovation Australia. ariia Adelaide: Flinders University; 2023 [updated 29/8/23. Available from: https://www.ariia.org.au/.

14. Jauncey S. From helpless to hopeful. Perth WA: Appellon; 2023 .

15. Royal Commission into Aged Care Quality and Safety. Final Report: Care Dignity and Respect. Canberra, ACT: Royal Commission into Aged Care Quality and Safety; 2021 26 February 2021.

16. Royal Commission into Aged Care Quality and Safety. Aged Care Royal Commission Final Report. Canberra: Royal Commission into Aged Care Quality and Safety; 2021 28 February 2021.

17. Welfare AIoHa. Consumers' experience of residential aged care: Australia 2017-2019. Canberra: Australian Institute of Health and Welfare; 2019.

18. Brooker D, Latham I. Person-centred dementia care: Making services better with the VIPS framework: Jessica Kingsley Publishers; 2015.

19. Siette J KG, Haddock R,. Quality of life tools to support measurement of aged care quality. Canberra, Australia: Australian Healthcare and Hospitals Association; 2022

Attachment A: Summary of results of Care-Rite survey analysis

This analysis of responses across six residential aged care homes shows:

- 77% of residents and 62% of family representatives agreed or strongly agreed that social, spiritual, psychological, and emotional support needs were met
- 76% of residents and 58% of family representatives agreed or strongly agreed that there was a sense of calm, contentment, meaning, purpose, and connection for residents
- Examples of how this support was provided included one-to-one talks with staff, activities provided by lifestyle staff, spiritual or religious interactions and family connections
- Family and friends contact was key to many residents feeling supported and belonging at the home
- Residents valued having time to talk with staff, especially lifestyle staff, when they were upset or discouraged by health or other issues
- Family representatives valued the support provided by staff to their relative
- Strategies used to support wellbeing offered by staff matched examples provided by residents. Examples included emotional and psychological support provided to residents who were worried or at end of life, opportunities to get to know residents through one-to-one chats or longer talks and knowing how to provide these strategies.
- There were low levels of disagreement by residents and family representatives that wellbeing choices were met or the degree of contentment and connection experienced.

The results of this analysis indicate mostly positive experiences for residents and family representatives in terms of their wellbeing and social connections. Staff identified the strategies needed to offer social, emotional, spiritual, and psychological support wanted by most residents.

While negative responses regarding wellbeing were uncommon, they related to lack of staff availability, lack of continuity with staff, and concerns about intrusive behaviour of some residents.

Staff were aware of gaps in their ability to provide the level of support needed by some residents. They cited staffing constraints and insufficient time to spend with residents in talking while completing care tasks. Where the lifestyle staff and allied health team were

organised and available, staff reported that residents had more wellbeing support and social connections.