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Putting the Consumer's Voice at the Centre of Residential Aged Care

Chief Investigators

Marita McCabe, Institute for Health and Ageing, ACU

Elizabeth Beattie, The Dementia Collaborative Research Centre, QUT

Gery Karantzas, School of Psychology, Deakin University

David Mellor, School of Psychology, Deakin University

Kerrie Sanders, Institute for Health and Ageing, ACU

Lucy Busija, Institute for Health and Ageing, ACU

Belinda Goodenough, Dementia Training Australia, University of Wollongong

Michelle Bennett, School of Allied Health, ACU

Kathryn von Treuer, Cairnmillar Institute

Research Staff

Jessica Byers, Institute for Health and Ageing

Jeretine Tan, Institute for Health and Ageing

Benjamin Fox, Queensland University of Technology

Catherine Travers, Queensland University of Technology

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EXECUTIVE SUMMARY

The advent of Consumer-Directed Care (CDC) in Australian Residential Aged Care Facilities (RACFs) will require a revolutionary change in the service delivery mind-set. This project will support this revolution through the implementation and evaluation (efficacy and cost) of our training program, the *Resident at the Centre of Care (RCC).* The project relates to the following key areas: identifying critical information and knowledge pathways necessary to create innovation in CDC practice in the aged care provider sector, facilitating communication between residents and staff and implementing organisational change so that CDC can be operationalised. Our RCC training program provides RACFs with a model for the implementation of CDC. The program includes development of clinical skills (e.g. communications with residents) and information gathering tools (e.g. the Resident Care Form) to operationalise a consumer-directed care plan, but also, importantly, provides training to support organisational change and transformational leadership that will be required for the significant shift from current resident care models to CDC practices into RACFs. The 6-session RCC program has been implemented by our CDC facilitators in Melbourne and Queensland RACFs and has identified and examined barriers and enablers to: Improve communication between residents and staff; Implement a resident-driven care plan (the Resident Care Form); Foster transformational leadership (in senior staff); and Work towards organisational change to accommodate CDC. Our project addresses these challenges by training staff in RACFs to meet the often-complex individual care needs of each care recipient, substantial regulatory burden, and mounting consumer expectations of aged care services, including consumers demanding greater choice in their care, and to be treated with dignity and have greater autonomy and independence. The RCC program has been evaluated in terms of the resident quality of life (QoL) and satisfaction with care, RACF staff satisfaction (via stress, turnover), organisational improvements (adherence to CDC) and program cost (economic evaluation). No other program designed to implement CDC in RACFs has been delivered and evaluated in Australia. Importantly, this project will inform government on CDC implementation strategies in RACFs, and highlight the economic costs for organisations to become "CDC ready".

The results of our evaluation of the RCC program demonstrated an increase in resident wellbeing in both training groups compared to the care as usual group, but minimal change in staff or organisational measures. The *training + support* condition demonstrated more favourable outcomes than the *training only* condition, which was more positive for residents than the care as usual condition. Given the substantial upheaval in the operations of the RACFs that implemented the RCC program, it is not surprising that three months after the training staff, were still experiencing difficulties in changing their ways of working, as well as the operations of the organisation, to accommodate the new model of care. With increased time, it is expected that these staff and organisational measures would improve. A longer follow-up time would indicate whether or not this is the case.

The economic evaluation has provided information on the main cost drivers for the RCC intervention. Including management staff in the training and support sessions adds significant costs to the program. Further research is required to determine whether the benefit of including management staff and their high associated cost is worthwhile. Overall, the economic evaluation was not able to determine if the increased cost of providing organisational support with training is justified in the longer follow-up time after training and support (and extra associated costs of support training). Future studies require improved costing information to more competently assess the cost-effectiveness of the RCC program.

The RCC program demonstrated that training staff in strategies to implement CDC in RACFs can lead to an improvement in the wellbeing of residents to ensure that the principles of CDC are embedded in practice in all RACFs.

OVERVIEW

Australia is striving towards a residential aged care system that is both centred on and directed by the consumer. Consumer Directed Care (CDC) is designed to support older people to make decisions about their care and everyday routines and to have a care plan that is, where possible, directed by them. It is expected that the Government will mandate CDC for Residential Aged Care Facilities (RACFs) in the very near future. The impending introduction of CDC in RACFs will require service providers to change how they deliver care to improve the quality of life (QoL) of residents. When adopted, organisations will need to respond rapidly in both 'mind-set' and 'logistics of' service delivery. Yet the required knowledge (e.g. implementation strategies, approach, costings) is largely missing for the Australian aged care sector. The aim of this study was to support our RACF partners by implementing and evaluating (both efficacy and cost of) a staff training program that would facilitate the transition to CDC practice in their facilities.

Although some RACFs have incorporated some aspects of CDC (e.g. meal times, activities) into their approaches to care, there is no program that includes all aspects of CDC. That is, a comprehensive approach has not been developed or implemented that includes all aspects of care (e.g. a daily routine of activities, meals and care that is completely directed by the resident). Further, no CDC- oriented intervention has been rigorously evaluated for its effectiveness or economic impact. This study outlines the outcomes from implementing our Resident at the Centre of Care (RCC) Program and imbedding it into routine practice. A core feature of RCC is the development of the capacity of senior staff to manage organisational change through transformational leadership, in order to drastically alter the way in which RACFs provide care for residents. We also conducted a detailed analysis of costings of resources required to implement our RCC program.

Gaps in CDC implementation and evaluation within RACFs

National and international examples of CDC in RACFs are limited. The majority of studies explore CDC delivery in community aged care.[1-2] Our project rectifies this gap by providing an innovative approach for CDC implementation in Australian RACFs. Additionally, while some person-centred approaches have been evaluated in the Australian aged care context[3-4] (with some positive outcomes), staff training programs where staff are trained to ensure that decision making about care is directed by the resident (i.e. CDC), have not been evaluated in RACFs. Furthermore, in the context of escalating costs, economic analyses of CDC training programs are desperately needed to guide cost effectiveness and sustainable rollout across the Australian aged care system. Our project attempted to rectify this gap by providing an evaluation of both CDC efficacy and cost in Australian RACFs.

Critical factors for sustainable change

Our research and that of others has identified a range of critical factors for sustainable evidence-based change in aged care practices. Difficulties associated with implementing a resident-directed approach include the lack of staff empowerment to handle the shift towards CDC philosophy, job restructuring, resistance to change, and the need for strong leadership.[5] There is a pressing need for workforce training (care staff and facility management) to implement CDC approaches, which also potentially includes appropriate attention to change management and leadership strategies.

Transformational leadership

Our research in RACFs[5-6] has demonstrated that a transformational style of leadership is more likely to engage and generate positive feelings and attitudes about organisational change among care staff. Transformational leaders are able to generate awareness and acceptance amongst followers for mission and purpose that leads to a wide variety of positive outcomes.[7] By definition then, transformational leaders are focused on change.[8] This style of leadership is essential to translate the knowledge and skills regarding CDC into practice and bring about the critical change in the focus of services that are provided for residents in RACFs.

Organisational climate variables

The proposed focus of CDC on resident needs, rather than care delivery, is a fundamental change in how a RACF may function. Aspects of staff relationships and organisational change, such as role clarity and innovation,[9] commitment and trust, will be essential to this focus shift. Our previous work with 255 aged care workers across 21 RACFs demonstrated that work pressure, innovation, and transformational leadership were predictive of aged care employee perceptions of organisational readiness for change. Therefore, the organisational climate is critical to translating the CDC strategies into practice.[10]

Workplace alliance

Beyond organisational factors, relationships between RACF care staff and care recipients is central to the success of CDC. Meaningful relationships can improve both resident QoL[11] and staff job satisfaction.[6, 12] In our project, we implemented a pragmatic approach to CDC delivery which focused on the working alliance. We worked with staff on implementing strategies for developing: (1) agreement on the care tasks (between carer and resident and/or family), (2) agreement on the goals of care (between carer and resident and/or family), and (3) a more equal partnership between carer and resident.

Our RCC training program has been developed to address these critical factors (working alliance, transformational leadership, organisational climate variables) in order to drive real and sustainable change towards implementing and imbedding CDC in residential aged care.

Research translation strategy: from education to practice change

Education (training) alone is typically necessary but insufficient for driving practice change. This "know-do" gap is a particular risk for large-scale reforms (like CDC) which may be viewed ambivalently as it is disruptive for established routines. Our research translation strategy will involve a close working relationship with RACFs and use the Dementia Training 4-stage 'Awareness-Agreement-Adoption-Adherence' approach to designing continuing education for health professionals.[13] These processes are embedded in the RCC program to enable practice change.

- *Awareness:* Our first goal was to raise awareness of CDC and CDC approach of care;
- *Agreement:* The second strategic goal involved ensuring agreement (values oriented "staff buy in") for CDC via our RCC program at participating sites. This agreement stage is vital: to empower local leaders to drive the intervention – helping teams internalise and own the initiative, as a foundation for sustainability beyond the research project timeframes.
- *Adoption:* The third strategic goal was adoption of CDC, through RCC program implementation. We will use a co-creation approach – staff will work in facilitated sessions to generate locally relevant, feasible and evidence-based implementation processes.
- *Adherence:* The fourth strategic goal addresses sustained practice change. Fostering individual staff adherence post-training will involve a range of tailored staff-preferred methods such as simple reminders (e.g. poster prompts in key locations in the facility) to complete specific tasks (e.g. the needs checklist for residents).

METHOD

Procedure

The RCC program was implemented and evaluated in a three-arm cluster RCT research design (see Figure 1) with 6 facilities randomly allocated into one of the three conditions (2 sites in each):

- Condition 1 (training + support): Implementation of the 6-session RCC Program among managers, RNs, Personal Care Attendants (PCAs), lifestyle and kitchen staff. Additional organisational support was provided for one day per week for four weeks following Session 4 and a further one day per week for 12 weeks following Session 6. The research personnel providing support worked with staff to assist them to create the climate in which CDC can prosper and to ensure the embedding and sustainability of the leadership and organisational changes from the RCC program.
- Condition 2 (training only): Implementation of the RCC Program among managers, RNs and PCAs as well as lifestyle and kitchen staff; no organisational support.
- Condition 3: a 'care as usual' control group.

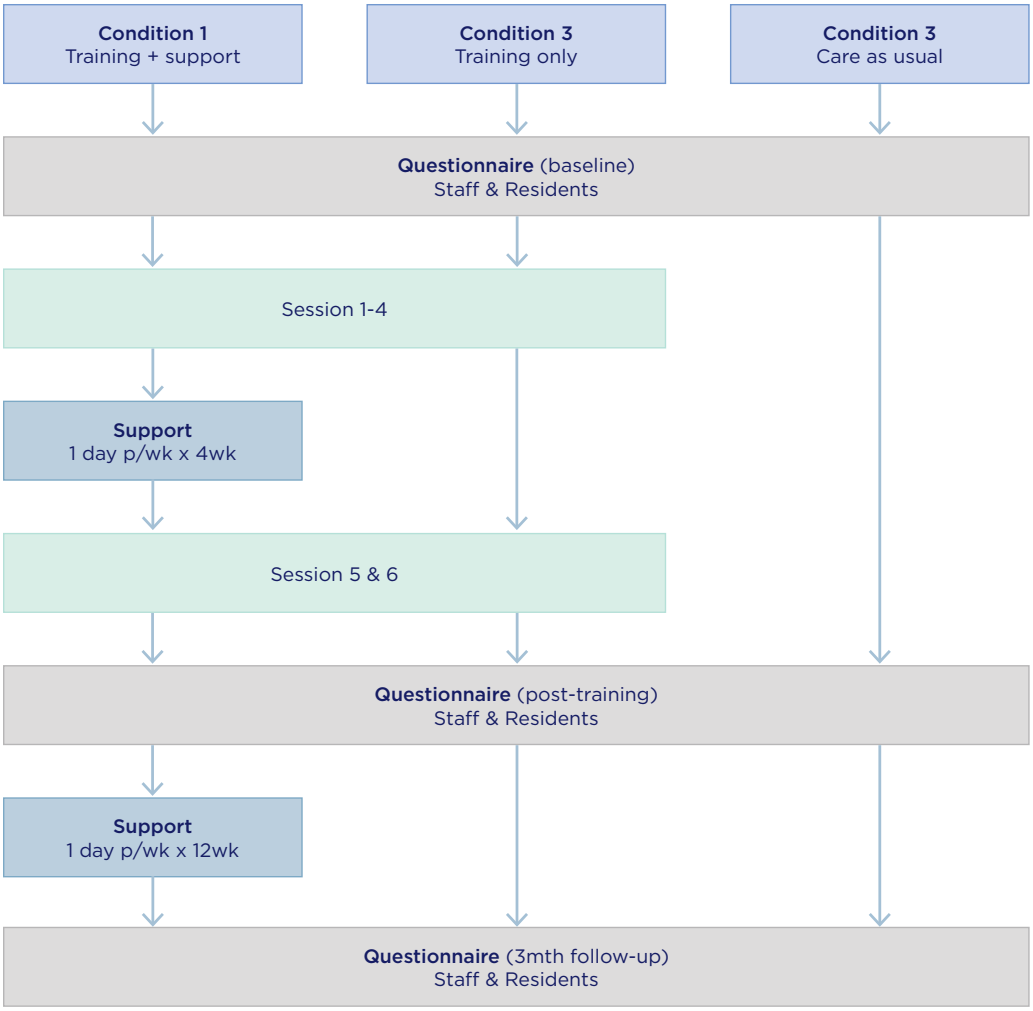

Figure 1. Research design

The effectiveness of the RCC Program in improving resident QoL and staff job satisfaction and reducing staff stress and turnover was determined through a timeline of evaluations planned for pre/ post-intervention and at 3 months follow up. We assessed whether RCC training resulted in effective CDC implementation (comparison of Conditions 1 and 2 with the control Condition 3) and if the provision of additional organisational support resulted in better sustainability of CDC implementation (comparisons of Conditions 1 and 2). Even if some aspects of CDC were currently being adopted in some facilities, we would expect our comprehensive RCC program (Conditions 1 and 2) to effect greater changes in resident and staff measures compared to care as usual (Condition 3) as well as testing the value of additional organisational support.

Participants

The participants were aged care residents and staff recruited from RACFs managed by our partner organisations. Informed consent was obtained from facility managers, staff, and the residents themselves, or if they are unable to provide consent because of communication or cognitive difficulties, from their family or guardian. All data were de-identified when they were coded and questionnaires were kept confidential to the researchers. Every resident at each participating site who met the following inclusion criteria were invited to take part: Residents older than 65 years and living in the RACF for more than three months. Exclusion criteria were: i) acute medical illness likely to compromise participation in the program; ii) inability to effectively communicate due to no English language or severe dementia (PAS score >15).

In the report, we are only reporting the analyses from the three Melbourne sites, as various unforeseen circumstances slowed down the gathering of data from the three Queensland sites. These data will be included when the complete findings are submitted for publication.

Table 1. Total participants at each assessment point

	Care as usual	Training only	Training + support	Total
Resident				
Baseline (T1)	13	14	17	44
Follow-up (T3)	12	12	8	32
Staff				
Baseline (T1)	15	15	22	52
Post-training (T2)	14	12	18	44
Follow-up (T3)	11	12	9	32

THE RESIDENT AT THE CENTRE OF CARE PROGRAM

Our program was designed to increase staff awareness and understanding of CDC, educate staff on the use of a Resident Care Form (see Appendix 1) to obtain resident choices on care, empower leaders to address the organisational barriers to implementing CDC and support staff in this implementation process.

Session 1: Awareness

This session aimed to clarify for the staff in leadership roles the key CDC principles, what CDC means within residential aged care, as well as the challenges and enabling factors to successful CDC implementation (e.g., cognitive capacity). Tools such as the Resident Care Form were used to foster the collaborative working relationship between the carer and the resident(s) as well as obtain the resident preferences. The focus was on implementing these preferences in order to improve the QoL of residents. The key organisational factors (i.e. staff autonomy and recognition; workplace fairness and innovation; trust; support and cohesion) will be discussed with the participants. The Barriers and Enablers Worksheet (see Appendix 2) is another tool that was used during activities to facilitate discussions around the key factors that can pose as challenges or facilitators to the success of CDC implementation and sustainability within the facility. In our pilot study we have found this Worksheet to be particularly useful in building the CDC approach that works for each facility.

Session 2: Transformational leadership

This session aimed to build staff skills in key domains of organisational climate, such as communication, teamwork, trust, support, cohesion, and also build staff autonomy among colleagues. Transformational leadership skills and qualities integral to achieving as a driver for positive organisational climate behaviours among staff. Senior staff members were encouraged to use their transformational leadership skills to facilitate the participation of other staff members in the remainder of the program.

Session 3: CDC implementation

Senior staff members were co-facilitators for Sessions 3 and 4. Session 3 included “on the floor staff” as well as senior staff. It covered what CDC means to the staff, and explored the prior knowledge, ideas, values and experiences with CDC implementation. The importance of building and maintaining a collaborative working relationship with the residents was emphasised. The Resident Care Form was introduced to facilitate working collaboratively with residents and their families, to give the care recipients increased opportunity for choice and autonomy in developing their individualised care plans. The final Resident Care Form was tailored to individual facilities, and hence looked different across all aged care facilities. However, it was benchmarked to ensure it covered off on its adherence to the principles of CDC.

Session 4: Barriers and enablers

The general staff members were introduced to the Barriers and Enablers Worksheet (see Appendix 2) to brainstorm ideas around the factors that can either hinder or promote successful CDC implementation and sustainability within their facility. The senior staff used their transformational leadership and communication competence skills to work with, and facilitate, the completion of this activity by other staff members.

There was a 4-week break between Session 4 and 5 to implement and build on the CDC checklist with residents, and note any additional barriers and enablers arising during these 4 weeks.

Session 5: Content and process

This session engaged participants in a discussion around how the Resident Care Form was working- i.e., the Content (what is included in the checklist) and the Process (how do you put this into practice) of implementing this in their facility. Using a solution-focused approach, participants focused on strategies involved in establishing and maintaining a collaborative relationship with the residents, as well as the key areas of resistance within the workplace climate that can hinder the effective implementation of CDC procedures.

Session 6: CDC implementation plan

The session focused on the development and finalisation of a CDC implementation plan that would work for each facility. This involved a discussion of the barriers and facilitators for organisational factors, as well as establishing and maintaining a collaborative relationship with the residents through the implementation of the Resident Care Form. Brainstorming was used to help staff create a flow chart of process and policy relating to CDC implementation within their facility to improve the QoL of residents.

OUTCOME MEASURES

The following measures were completed by all staff and residents at pre-intervention, post-intervention and 3-month follow up (or equivalent time for the care as usual group).

Resident measures

A complete copy of resident measures is located in Appendix 3.

Primary outcome

Quality of life was assessed with the Quality of Life-AD (QoL-AD) Aged Care Adaptation,[14] comprising items measuring physical health, mood, memory, functional abilities, interpersonal relationships and engagement in meaningful activities. This measure was completed by interview with the resident.

Secondary outcomes

Resident perceptions *Working alliance* was assessed utilising an adapted version of the Scale to Assess Therapeutic Relationships in Community Mental Health Care (STAR).[15] The measure consists of 11 items to assess resident perceptions of their relationship with staff. All items are summed to provide an overall working alliance score.

Perceptions of CDC practice was measured by a scale developed by the research team for this study. This measure taps into the core elements of Consumer Direct Care (CDC) by assessing residents' experience of their care. Items such as "I would like to do more for myself" and "I am happy with how much choice I am given about my care" assess the residents' level of involvement in their care and decisions about their care.

Satisfaction with care was evaluated by a measure developed for this pilot study. This measure assessed resident satisfaction across 14 key Activities of Daily Living (ADLs). This measure also assessed whether resident needs were currently met for each ADL. Any requests for change (e.g. change the way care was delivered, access to services, or engagement in activities) were noted.

Core psychological needs – *autonomy, competence and relatedness* – were assessed using the 18-item Balanced Measure of Psychological Needs.[16] This measure provides a score for each subscale, indicating to what degree resident needs are met.

Organisational Climate & Leadership Style

Secondary outcomes

Staff perceptions regarding organisational climate was assessed using the Organisational Climate Questionnaire (OCQ).[17] The OCQ consists of 40 items that tap into the eight subscales that constitute organisational climate – trust, autonomy, fairness, innovation, pressure, cohesion, support, and recognition.

Transformational leadership was assessed using the transformational leadership subscales of the Multifactor Leadership Questionnaire (MLQ) developed by Bass and Avolio[18]. The MLQ comprises a series of subscales which include idealised influence (attributes and behaviours encouraging employees to share common clear vision and a strong sense of purpose), inspirational motivation (inspiring employees to work towards the mission of the organisation), intellectual stimulation (challenge old assumptions, and stimulate new ideas), and individualised consideration (understanding employees needs and helping them enhance their capacities). Subscales can be summed to form a total transformational leadership score.

In addition, information was gathered on other organisational factors that could potentially affect study outcome (e.g., change in leadership, staff training unrelated to CDC, other internal programs related to CDC implementation, current level of CDC).

Staff measures

A complete copy of staff measures is located in Appendix 4. In addition to outcome measures, staff also completed a form to provide feedback about their experience of the RCC training program (Appendix 5).

Secondary outcomes

Perceptions and practice of CDC measures staff perceptions about the presence of CDC practices in their RACF. This 11-item scale was created by the research team for this study. Items such as "Residents are able to decide what is in their care plan" and "I believe residents could do more for themselves" assess staff perceptions of residents' involvement in care.

OUTCOME MEASURES CONTINUED

Working alliance was assessed utilising an adapted version of the Scale to Assess Therapeutic Relationships in Community Mental Health Care (STAR).15 The measure consists of 11 items to assess staff perceptions of their relationship with residents. All items are summed to provide an overall working alliance score.

Intention to quit was measured with a two item scale: 'How often do you think about leaving your job?' rated on a 5-point scale from 1 [never] to 5 [always], and 'How likely are you to look for a new job within the next year?'.[19]

Staff *job satisfaction* was measured by the 8-item job satisfaction subscale of the workplace scale,[19] measuring extrinsic/intrinsic costs and rewards associated with an individual's job.

Control Variables

Staff perceptions of their facility's readiness for organisational change was measured using the 25-item scale, Readiness for Organisational Change.[17] This measure comprises of four subscales: *the appropriateness of the change, management support for the change,* employee confidence in their ability to perform well and be successful following the change (*change efficacy*), and whether staff perceive the change as *personally beneficial* (in terms of status, relationships and job opportunities).

RESULTS

This section provides an overview of the data collected from the RCC pilot study. Information has been collated into the following broad categories:

- Resident care & choice
- Barriers and enablers to CDC implementation
- Resident factors
- Staff factors
- Organisation factors

Resident care & choice

Resident satisfaction with care (medical, social and lifestyle) was assessed at baseline and follow-up. The following table summarises resident satisfaction by Activity of Daily Living (ADL). The proportion of happy versus unhappy residents is reported for each ADL, both at baseline and at the 3-month follow-up. Data is also presented for the proportion of residents who requested to change some aspect of their care.

Please note that for ADLs referring to assistance provided by staff (e.g. bathing, dressing), the proportion reported is based on the total residents who receive assistance for that ADL (i.e. it does not include residents who are independent in the ADL). The first column of data at each time point (N/A) reports the proportion of residents who are independent in each ADL.

At the training + support site a larger proportion of residents required assistance with personal ADLs (e.g. bathing, toileting), whereas the majority of residents at the training only site were relatively independent. Residents at the care as usual site were a fairly mixed group in terms of independence (i.e. need for assistance).

Table 2. Resident satisfaction by ADL (Care as usual)

ADL	Baseline (T1)				Follow-up (T3)			
	Independent	happy	unhappy	change requested	Independent	happy	unhappy	change requested
Wake up & bedtime				8.3				16.7
Waking	75.0	16.7	8.3	-	75.0	16.7	8.3	-
Prepare for bed	75.0	25.0	0.0	-	83.3	16.7	0.0	-
Dressing	81.8	18.2	0.0	0.0	63.6	36.4	0.0	0.0
Bathing	50.0	50.0	0.0	10.0	50.0	41.7	8.3	9.1
Grooming	66.7	16.7	16.7	14.3	83.3	16.7	0.0	9.1
Pampering & beauty	41.7	50.0	8.3	0.0	75.0	25.0	0.0	9.1
Skin care	66.7	25.0	8.3	14.3	58.3	41.7	0.0	0.0
Toileting	91.7	8.3	0.0	20.0	75.0	16.7	8.3	9.1
Pain management	58.3	41.7	0.0	0.0	16.7	66.7	16.7	25.0
Move around	83.3	16.7	0.0	14.3	58.3	33.3	8.3	9.1
Transfers	91.7	8.3	0.0	0.0	66.7	25.0	8.3	9.1
Medical & Allied Health								
Services received	-	91.7	8.3	16.7	-	100.0	0.0	33.3
Knowledge of services	-	50.0	50.0	-	-	75.0	25.0	-
Social life	-	75.0	25.0	0.0	-	91.7	8.3	33.3
Lifestyle activities	-	91.7	8.3	29.2	-	91.7	8.3	25.0
Eating & drinking	83.3	8.3	8.3	14.3	66.7	33.3	0.0	0.0
Meal & drink options	-	66.7	33.3	58.2	-	83.3	16.7	33.3
Conversations				41.7				0.0
Enough people to talk to	-	75.0	25.0	-	-	83.3	16.7	-
Enough opportunity to talk	-	66.7	33.3	-	-	72.7	27.3	-

Table 3. Resident satisfaction by ADL (Training only)

ADL	Baseline (T1)				Follow-up (T3)			
	Independent	happy	unhappy	change requested	Independent	happy	unhappy	change requested
Wake up & bedtime				0.0				0.0
Waking	83.3	16.7	0.0	-	100.0	-	-	-
Prepare for bed	100.0	-	-	-	100.0	-	-	-
Dressing	91.7	8.3	0.0	0.0	100.0	-	-	0.0
Bathing	75.0	25.0	0.0	10.0	83.3	16.7	0.0	0.0
Grooming	100.0	-	-	0.0	83.3	16.7	0.0	0.0
Pampering & beauty	75.0	25.0	0.0	10.0	75.0	25.0	0.00	0.0
Skin care	75.0	25.0	0.0	0.0	75.0	25.0	0.0	0.0
Toileting	91.7	8.3	0.0	0.0	91.7	8.3	0.0	0.0
Pain management	25.0	75.0	0.0	0.0	33.3	58.3	8.3	8.3
Move around	90.9	9.1	0.0	11.1	100.0	-	-	0.0
Transfers	100.0	-	-	0.0	100.0	-	-	0.0
Medical & Allied Health				9.1				9.1
Services received	-	100.0	0.0	-	-	100.0	0.0	-
Knowledge of services	-	50.0	50.0	-	-	80.0	20.0	-
Social life	-	91.7	8.3	8.3	-	91.7	8.3	16.7
Lifestyle activities	-	91.7	8.3	8.3	-	83.3	16.7	25.0
Eating & drinking	100.0	-	-	0.0	100.0	-	-	0.0
Meal & drink options	-	66.7	33.3	50.0	-	66.7	33.3	50.0
Conversations				25.0				0.0
Enough people to talk to	-	91.7	8.3	-	-	91.7	8.3	-
Enough opportunity to talk	-	100.0	0.0	-	-	71.4	16.7	-

Table 4. Resident satisfaction by ADL (Training + support)

ADL	Baseline (T1)				Follow-up (T3)			
	Independent	happy	unhappy	change requested	Independent	happy	unhappy	change requested
Wake up & bedtime				12.5				37.5
Waking	62.5	25.0	12.5	-	50.0	50.0	0.0	-
Prepare for bed	50.0	50.0	0.0	-	62.5	37.5	0.0	-
Dressing	25.0	62.5	12.5	37.5	62.5	37.5	0.0	0.0
Bathing	25.0	62.5	12.5	50.0	50.0	37.5	12.5	0.0
Grooming	50.0	37.5	12.5	50.0	75.0	25.0	0.0	0.0
Pampering & beauty	37.5	50.0	12.5	20.0	62.5	37.5	0.0	0.0
Skin care	25.0	62.5	12.5	33.3	50.0	50.0	0.0	0.0
Toileting	75.0	25.0	0.0	0.0	75.0	25.0	0.0	0.0
Pain management	25.0	50.0	25.0	50.0	37.5	62.5	0.0	0.0
Move around	62.5	25.0	12.5	100.0	42.9	57.1	0.0	0.0
Transfers	62.5	12.5	25.0	100.0	42.9	57.1	0.0	0.0
Medical & Allied Health				62.5				0.0
Services received	-	75.0	25.0	-	-	100.0	0.0	-
Knowledge of services	-	75.0	25.0	-	-	57.1	42.9	-
Social life	-	75.0	25.0	37.5	-	85.7	14.3	20.0
Lifestyle activities	-	87.5	12.5	58.9	-	85.7	14.3	14.3
Eating & drinking	62.5	37.5	0.0	0.0	71.4	14.3	14.3	0.0
Meal & drink options	-	75.0	25.0	87.5	-	83.3	16.7	42.9
Conversations				50.0				0.0
Enough people to talk to	-	62.5	37.5	-	-	85.7	14.3	-
Enough opportunity to talk	-	62.5	37.5	-	-	71.4	28.6	-

BARRIERS & ENABLERS TO CDC IMPLEMENTATION

The RCC program asked staff to consider the potential barriers and enablers to implementing a CDC model of care.

These barriers and enablers were explored according to the organisational factors essential to successful implementation: staff autonomy and recognition, workplace fairness and innovation, trust, support and cohesion, and workplace pressure. These organisational factors provided a framework for staff and helped elicit detail to identify the areas for change in each organisational factor within their RACF.

A summary of the barriers and enablers gathered from both intervention sites is presented below.

Staff autonomy & recognition

Staff autonomy relates to staff being able to initiate, prioritise and drive the work they do. Staff autonomy is related to a sense of independence, self-determination and motivation in the workplace.

Staff recognition describes the importance of explicitly acknowledging the capabilities, skills and achievements of all staff.

BARRIERS	ENABLERS
• Don't stop to recognise achievements • Over-critical • Assumptions about others • Government legislation and regulations (inc. audits) • Hierarchy systems for reporting • Lack of initiative at client level (due to system boundaries) • System restrictions • Residents being resistive/duty of care • Access to resources	• Saying thank you • Acknowledging a job well done • Accepting each other's strengths and differences • Respect staff choices and decisions • Clarity of role and responsibilities • Appreciation of strengths • Clear guidance from team leaders • Leadership team on the floor to provide support to carers when needed • Affirmation from other staff • Increased focus on skills, not mistakes

Workplace fairness & innovation

Workplace fairness describes fair and equitable practices across all levels of staff. It also relates to the importance of policies or procedures being transparent and consistently applied.

Innovation describes the process of encouraging staff to embrace change and approach challenges creatively and collaboratively.

BARRIERS	ENABLERS
• Assumptions and expectations of others • Assumptions about work relationships (friendships); in group, out group • Funding • Time • Resources • Legislation • Historic behaviours (e.g. task focussed) and remaining in comfort zone • Sticking with procedures rather than being innovative	• Building healthy work relationships • Recognise goals may have their own time lines • Supporting and nurturing new ideas • Providing forums for open discussion in a safe environment • Improving problem solving skills • Sharing information • Look at the big picture • Measure quality of life, not tasks • Be a role model for others to follow

Trust

Trust in the workplace means that staff feel confident that their colleagues are able to meet their needs in relation to work tasks. This includes being able to trust that colleagues will be supportive during challenging times and willing to find a collective resolution.

BARRIERS	ENABLERS
• Effective communication • Expectations of self [to respond to resident requests] • Expectations of resident and family	• Regular, consistent trust from colleagues & leadership team • Open and honest communication • Building a good relationship • Positive and supportive body language and attitudes at work • Foster a comfortable environment and relationship with your team • Support from families with the implementation of CDC • Follow-up

Support & cohesion

Support in the workplace is the provision of emotional and practical resources to colleagues, not only at times of need but also during periods of positive achievements. Support fosters positive change in the work environment.

Cohesion describes a sense of relatedness and connectedness between staff. Organisational change benefits from cohesion by ensuring staff feel they are a part of a larger team.

BARRIERS	ENABLERS
• Communication between colleagues (sharing of information) • Staff reluctance to implement changes • Communicate between colleagues • Communication with team mates across different shifts	• Common goals and purpose • Good team (staff genuinely care) • Management support • Communicate effectively (Two-way communication between team leaders and general staff) • Multicultural acknowledgement and celebrations • Look after staff well-being • Supportive leadership

Workplace pressure

Workplace pressure describes the demands placed on staff to complete tasks and perform well. Recognising and addressing workplace pressure helps organisations prepare for, and manage the change process.

BARRIERS	ENABLERS
• Things come up last minute (e.g. staff on sick leave) • Residents being resistive/duty of care • Residents being resistive/duty of care • Moving from task to task • Documentation • Funding (for staff, equipment, etc.) • Number of staff • Time to implement CDC (competing work demands)	• More small group meetings on the floor • Improve communication and support across all levels of staff • Use of humour • Clear on roles and responsibilities

RESIDENTS

Resident data were collected across a range of domains, to capture the impact of CDC on key aspects of their life and wellbeing. Specifically, measures were completed at Baseline (T1) and again at the 3-month follow-up (T3) to assess the following:

- Quality of Life (QoL)
- Consumer Directed Care (CDC): perceptions of practice
- Working Alliance with staff
- Relatedness or connection to others
- Sense of competence
- Sense of autonomy

Table 5. Resident mean scores on key outcome measures

VARIABLE	BASELINE (T1)	FOLLOW UP (T3)	DIFFERENCE (T3 - T1)
Quality of Life			
Care as usual	42.43	42.73	0.30
Training only	44.50	48.81	4.31
Training + support	37.65	40.42	2.77
Consumer Directed Care			
Care as usual	19.87	20.98	1.11
Training only	21.75	23.72	1.97
Training + support	20.00	22.14	2.14
Working Alliance			
Care as usual	25.16	27.78	2.62
Training only	30.95	35.15	4.20
Training + support	23.90	27.98	4.08
Relatedness			
Care as usual	21.38	22.80	1.42
Training only	23.29	25.50	2.21
Training + support	20.76	25.14	4.38
Sense of Competence			
Care as usual	17.23	18.89	1.66
Training only	20.00	21.89	1.89
Training + support	18.60	19.29	0.69
Sense of Autonomy			
Care as usual	22.15	23.23	1.08
Training only	23.21	24.10	0.89
Training + support	19.42	21.86	2.44

Quality of Life

The measure of Quality of Life (QoL) assessed residents' perceptions across a range of life domains, such as physical health, mood, memory, functional ability, interpersonal relationships and engagement in meaningful activities. Higher scores relate to higher perceived QoL.

The data indicated that residents' QoL improved over time for both intervention groups, yet remained stable for the care as usual group. The residents in the training only group reported a greater increase in QoL (4.31 points) compared to the training + support group (2.77 points).

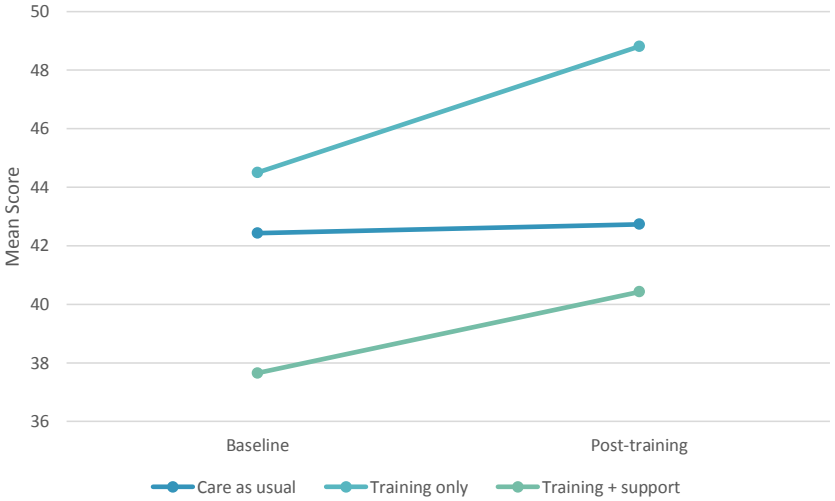

Figure 2. Quality of Life

Consumer Directed Care: Perceptions of Practice

This measure taps into the core elements of Consumer Direct Care (CDC) by assessing residents' experience of their care. Items such as "I would like to do more for myself" and "I am happy with how much choice I am given about my care" assess the residents' level of involvement in their care and decisions about their care. Higher scores indicate greater presence of CDC practices, as reported by residents.

Residents at all sites reported an increase in perceived CDC practices. The intervention groups display greater increases in CDC than the care as usual group. The training + support group demonstrated a larger increase in CDC than the training only group.

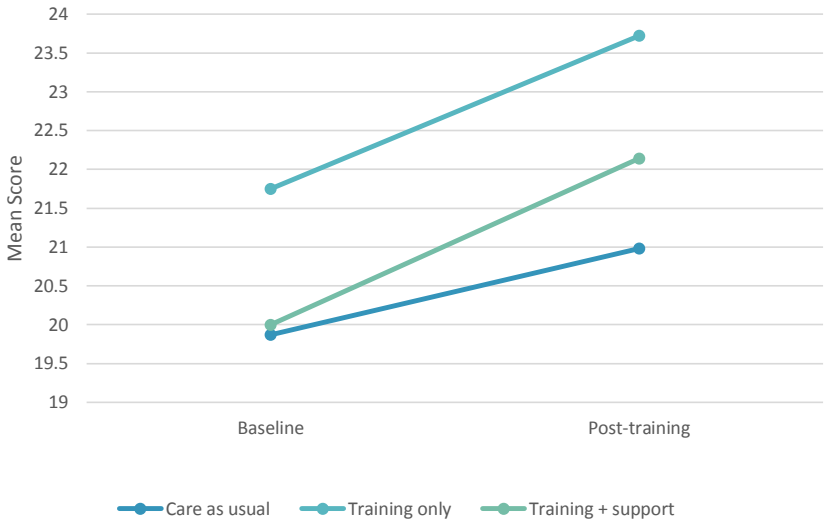

Figure 3. Consumer Directed Care: perceptions of practice

Working Alliance

Working alliance assessed residents' perceptions of the quality (e.g. trust, collaboration) of their relationships with care staff.

Residents at the intervention sites reported a greater improvement in working alliance (approximately 4 points) compared to the care as usual group, which demonstrated a small improvement between baseline and follow-up (2.62 points).

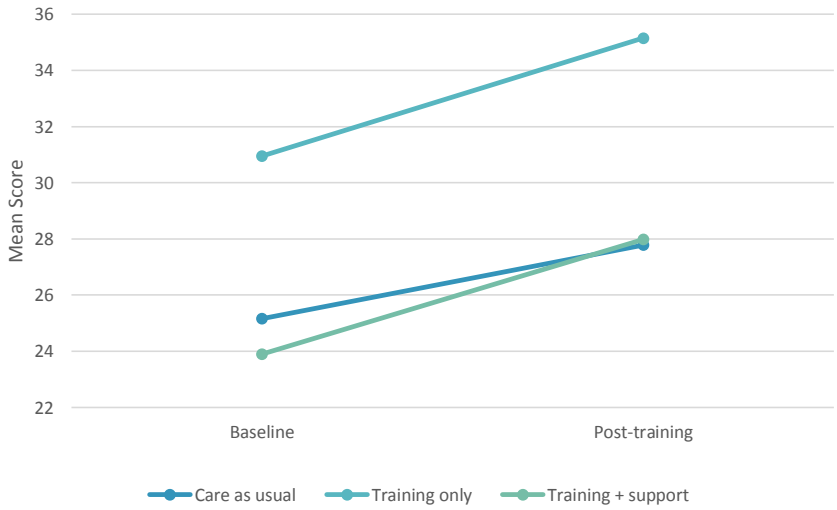

Figure 4. Working Alliance

Relatedness

The measure of relatedness describes whether residents' needs are met in terms of connectedness to people who are important to them (e.g. other residents, family, friends and staff). Higher scores indicate a greater sense of relatedness.

Residents' at both intervention sites reported an increase in relatedness, with the training + support group reporting a greater improvement than the training only group (4.38 and 2.21, respectively). A small increase in relatedness was reported by residents in the care as usual group (1.42 points).

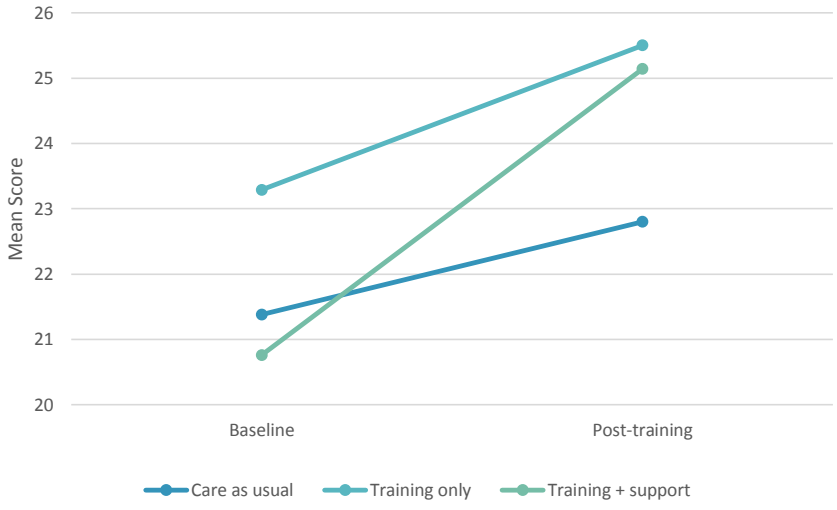

Figure 5. Relatedness

Sense of Competence

Competence assess the degree to which residents feel capable and effective. Higher score indicate a greater sense of competence.

Residents at both the care as usual and training only sites reported a small increase in levels of perceived competence. However, levels of perceived competence remained stable for residents at the training + support site.

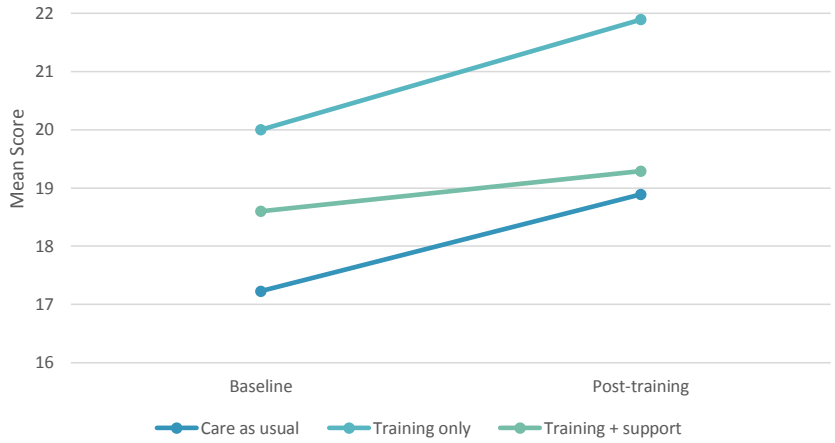

Figure 6. Sense of competence

Sense of Autonomy

Autonomy describes the need for residents' to influence their lives in a concrete, meaningful way. It also captures the importance that residents place on feeling able to freely express themselves. Higher scores relate to greater sense of autonomy.

Residents at the training + support group reported an increase in perceived autonomy, whereas the care as usual and training only groups show no discernible change.

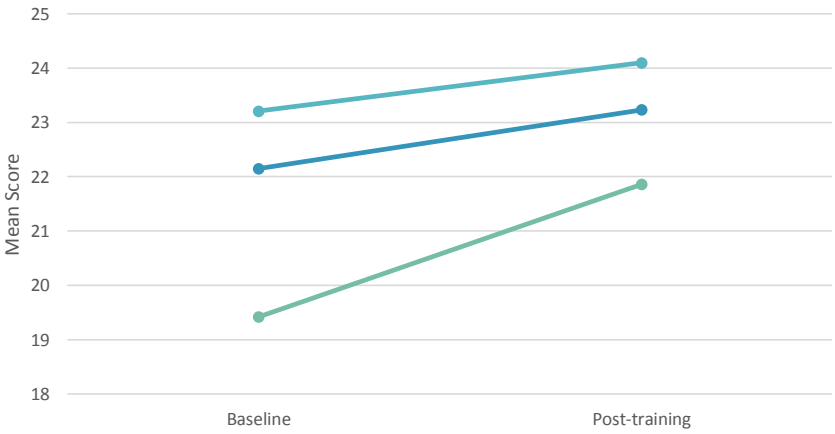

Figure 7. Sense of autonomy

STAFF

Staff data were collected to capture the impact of a CDC model of care on key aspects of their work role. Measures were completed at Baseline (Time 1), post-training (Time 2) and again at the 3-month follow-up (Time 3) to assess the following:

- Consumer Directed Care (CDC)
- Working Alliance
- Job satisfaction
- Intention to quit

The mean scores, along with the change between baseline and follow-up, are presented in the tables below. These data have been examined separately for General and Senior staff, to allow for the differences in experience and subsequent perceptions of the different levels of staff.

Consumer Directed Care: Perceptions & Practice

This measure captures staff perceptions about the presence of Consumer Direct Care (CDC) in their RACF. Items such as "Residents are able to decide what is in their care plan" and "I believe residents could do more for themselves" assess staff perceptions of residents' involvement in care. Higher scores indicate greater presence of CDC practices, as reported by staff.

General staff at the training only site report an increase in CDC. This figure remained stable at the care as usual and training + support sites. In contrast, Senior staff members at both intervention sites reported an increase in CDC, while the care as usual site remained stable.

Table 6. Staff mean scores for Consumer Directed Care

GROUP	TIME 1	TIME 2	TIME 3	DIFFERENCE (T3 - T1)
General staff				
Care as usual	19.86	20.75	20.50	0.64
Training only	18.33	20.33	19.86	1.53
Training + support	19.30	18.60	19.80	0.50
Senior staff				
Care as usual	20.90	20.00	20.20	-0.70
Training only	19.98	22.17	22.88	2.90
Training + support	19.67	20.32	22.50	2.83

Figure 8. Consumer Directed Care: perceptions & practice (General staff)

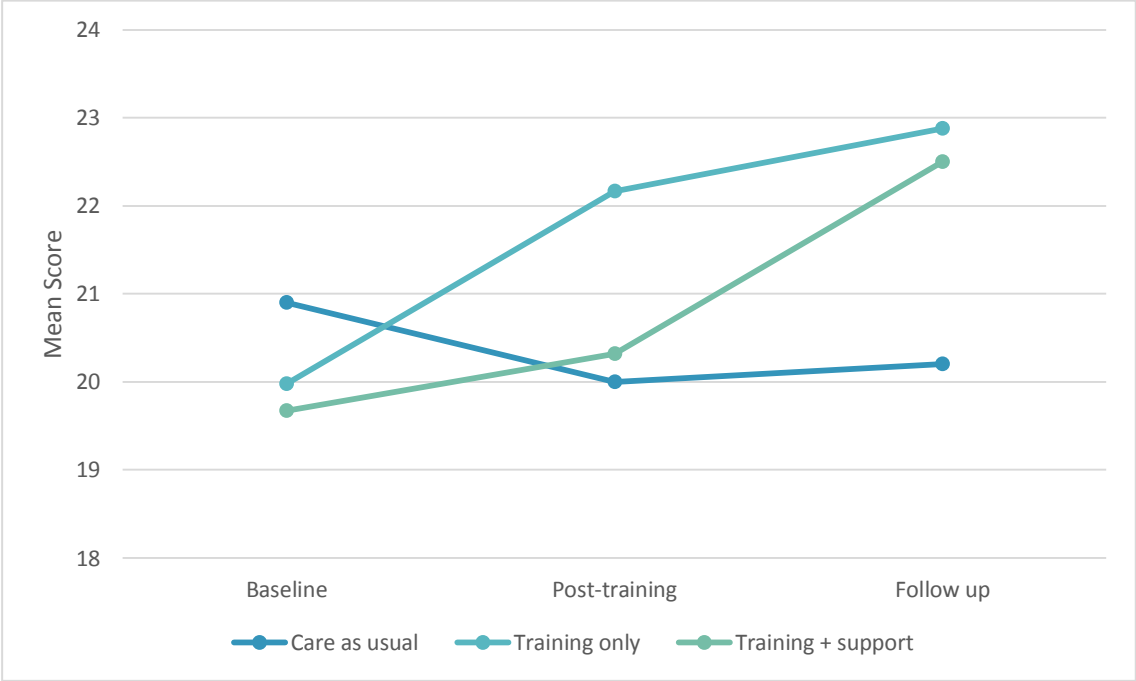

Figure 9. Consumer Directed Care: perceptions & practice (Senior staff)

Working Alliance

Working alliance assessed staff perceptions of the quality (e.g. trust, collaboration) of their relationships with residents.

Table 7 provides a summary of the mean scores relating to working alliance, at each measurement time point. The final column provides the difference in mean scores between Baseline (Time 1) and Follow-up (Time 3).

Table 7. Staff mean scores for Working alliance

GROUP	TIME 1	TIME 2	TIME 3	DIFFERENCE (T3 - T1)
General staff				
Care as usual	34.00	33.88	31.17	-2.83
Training only	30.33	34.33	35.00	4.67
Training + support	35.90	32.70	30.40	-5.50
Senior staff				
Care as usual	32.32	30.17	32.00	-0.32
Training only	34.82	32.82	34.81	-0.01
Training + support	33.64	36.13	36.50	2.86

Job Satisfaction

This construct assess staff satisfaction across a range or work domains such as job security, physical conditions, recognition and role freedom).

Table 8 provides a summary of the mean scores relating to staff job satisfaction, at each measurement time point. The final column provides the difference in mean scores between Baseline (T1) and Follow-up (T3).

Table 8. Staff mean scores for Job satisfaction

GROUP	TIME 1	TIME 2	TIME 3	DIFFERENCE (T3 - T1)
General staff				
Care as usual	31.57	32.88	30.67	-0.90
Training only	26.33	27.83	28.00	1.67
Training + support	26.45	25.10	21.20	-5.25
Senior staff				
Care as usual	31.50	32.17	32.60	1.10
Training only	32.22	32.24	32.80	0.58
Training + support	29.00	27.91	28.75	-0.25

Intention to Quit

This construct measures intention to quit by gauging how often staff think about resigning and how likely they are to resign within the next 12 months.

Table 9 provides a summary of the mean scores for the measure of intention to quit, at each measurement time point. The final column provides the difference in mean scores between Baseline (T1) and Follow-up (T3).

Table 9. Staff mean scores for Intention to quit

GROUP	TIME 1	TIME 2	TIME 3	DIFFERENCE (T3 - T1)
General staff				
Care as usual	2.29	2.25	2.50	0.21
Training only	2.67	2.33	2.14	-0.53
Training + support	4.91	4.30	5.40	0.49
Senior staff				
Care as usual	2.00	2.33	1.80	-0.20
Training only	2.89	2.17	1.60	-1.29
Training + support	3.45	4.13	5.00	1.55

Transformational Leadership

This construct describes a style of leadership that is integral to the success of organisation change. Specifically, it comprises of four dimensions referred to as charisma, inspirational motivation, intellectual stimulation, and individualised consideration.

Table 10 provides a summary of senior staff mean scores on the measure of transformational leadership style, at each measurement time point. The final column provides the difference in mean scores between Baseline (T1) and Follow-up (T3).

Table 10. Senior staff mean scores for Transformation leadership

GROUP	TIME 1	TIME 2	TIME 3	DIFFERENCE (T3 - T1)
Senior staff				
Care as usual	3.03	2.84	3.02	-0.01
Training only	2.85	2.93	3.06	0.21
Training + support	3.15	3.05	3.21	0.06

ORGANISATIONAL FACTORS

Staff at all sites were asked to provide their perceptions of their RACF's readiness to change and organisational climate.

Organisational Readiness for Change

This construct measures employees' perceptions of their organisation's readiness to implement changes associated with introducing a CDC model of care. This construct comprises of four dimensions. The appropriateness of the change, management support for the change, employee confidence in their ability to perform well and be successful following the change (change efficacy), and whether staff perceive the change as personally beneficial (in terms of status, relationships and job opportunities).

The following table presents the means scores for each dimension of readiness to change, as assessed at baseline (T1). Higher scores indicate greater staff endorsement of their organisation's readiness for change.

Table 11. Mean scores for Organisational Readiness for Change

GROUP	GENERAL STAFF	SENIOR STAFF
Appropriateness (possible range: 10 – 50)		
Care as usual	34.14	36.00
Training only	38.50	30.75
Training + support	33.34	41.45
Personally Beneficial (possible range: 3 – 15)		
Care as usual	11.00	12.00
Training only	11.17	10.88
Training + support	11.36	12.64
Management Support (possible range: 6 – 30)		
Care as usual	18.29	22.75
Training only	18.50	19.44
Training + support	21.18	22.00
Change Efficacy (possible range: 6 – 30)		
Care as usual	21.86	23.75
Training only	21.83	23.44
Training + support	20.18	22.79

Organisational Climate

Organisational climate provides a description of employees' experiences within a specific workplace or unit. The climate of an organisation consists of a number of domains that interact to form a unique environment. These domain are staff autonomy and recognition, workplace fairness, innovation, trust, support, cohesion, and workplace pressure.

Autonomy

Staff autonomy relates to staff being able to initiate, prioritise and drive the work they do. Staff autonomy is related to a sense of independence, self-determination and motivation in the workplace.

Table 12. Staff mean scores for Autonomy

GROUP	T1	T2	T3	DIFFERENCE (T3-T1)
General staff				
Care as usual	16.43	18.38	16.60	0.17
Training only	15.20	16.50	15.57	0.37
Training + support	19.45	18.98	18.00	-1.45
Senior staff				
Care as usual	17.98	19.00	19.60	1.62
Training only	18.55	19.65	20.80	2.25
Training + support	17.18	17.79	19.00	1.82

Support

Support in the workplace is the provision of emotional and practical resources to colleagues, not only at times of need but also during periods of positive achievements. Support fosters positive change in the work environment.

Table 13. Staff mean scores for Support

GROUP	T1	T2	T3	DIFFERENCE (T3-T1)
General staff				
Care as usual	18.00	19.38	18.17	0.17
Training only	17.33	17.86	18.29	0.96
Training + support	16.45	15.70	14.60	-1.85
Senior staff				
Care as usual	19.25	18.00	20.00	0.75
Training only	18.44	18.33	19.00	0.56
Training + support	16.09	16.25	20.50	4.41

Trust

Trust in the workplace means that staff feel confident that their colleagues are able to meet their needs in relation to work tasks. This includes being able to trust that colleagues will be supportive during challenging times and willing to find a collective resolution.

Table 14. Staff mean scores for Trust

GROUP	T1	T2	T3	DIFFERENCE (T3-T1)
General staff				
Care as usual	18.23	19.00	16.83	-1.4
Training only	17.00	17.50	17.86	0.86
Training + support	16.91	16.10	16.20	-0.71
Senior staff				
Care as usual	19.38	19.33	20.00	0.62
Training only	17.78	17.83	20.60	2.82
Training + support	18.73	18.75	21.19	2.46

Cohesion

Cohesion describes a sense of relatedness and connectedness between staff. Organisational change benefits from cohesion by ensuring staff feel they are a part of a larger team.

Table 15. Staff mean scores for Cohesion

GROUP	T1	T2	T3	DIFFERENCE (T3-T1)
General staff				
Care as usual	18.86	20.63	18.33	-0.53
Training only	18.83	19.17	19.57	0.74
Training + support	18.55	17.50	15.60	-2.95
Senior staff				
Care as usual	20.50	19.50	19.40	-1.1
Training only	19.89	18.50	20.00	0.11
Training + support	17.61	19.04	20.50	2.89

Workplace Pressure

Workplace pressure describes the demands placed on staff to complete tasks and perform well. Recognising and addressing workplace pressure helps organisations prepare for, and manage the change process.

Table 16. Staff mean scores for Workplace pressure

GROUP	T1	T2	T3	DIFFERENCE (T3-T1)
General staff				
Care as usual	11.86	13.63	11.83	-0.03
Training only	14.00	13.67	13.86	-0.14
Training + support	14.85	15.40	17.00	2.15
Senior staff				
Care as usual	13.25	13.00	11.80	-1.45
Training only	12.78	14.23	13.80	1.02
Training + support	16.27	15.20	16.00	-0.27

Recognition

Staff recognition describes the importance of explicitly acknowledging the capabilities, skills and achievements of all staff.

Table 17. Staff mean scores for Recognition

GROUP	T1	T2	T3	DIFFERENCE (T3-T1)
General staff				
Care as usual	17.14	18.25	17.83	0.69
Training only	15.17	17.03	17.43	2.26
Training + support	15.73	14.10	14.40	-1.33
Senior staff				
Care as usual	18.50	19.33	19.80	1.3
Training only	18.00	19.00	19.20	1.2
Training + support	16.52	17.00	20.25	3.73

Fairness

Workplace fairness describes fair and equitable practices across all levels of staff. It also relates to the importance of policies or procedures being transparent and consistently applied.

Table 18. Staff mean scores for Fairness

GROUP	T1	T2	T3	DIFFERENCE (T3-T1)
General staff				
Care as usual	18.00	20.50	17.62	-0.38
Training only	18.17	18.40	18.81	0.64
Training + support	16.45	15.50	15.20	-1.25
Senior staff				
Care as usual	19.13	19.17	20.00	0.87
Training only	17.63	19.10	18.80	1.17
Training + support	16.91	15.75	17.25	0.34

Innovation

Innovation describes the process of encouraging staff to embrace change and approach challenges creatively and collaboratively.

Table 19. Staff mean scores for Innovation

GROUP	T1	T2	T3	DIFFERENCE (T3-T1)
General staff				
Care as usual	16.43	18.63	18.67	2.24
Training only	18.00	19.40	18.72	0.72
Training + support	16.73	16.20	15.00	-1.73
Senior staff				
Care as usual	19.81	20.00	20.00	0.19
Training only	19.38	19.20	22.01	2.63
Training + support	18.09	15.88	17.75	-0.34

ECONOMIC EVALUATION

Economic evaluation was undertaken alongside a pilot cluster-randomised controlled trial (RCT) of the Resident at the Centre of Care (RCC) Program.

Methods

The primary outcome measures used within the RCC program was the change in residents' responses on the Quality of Life in Alzheimer's Disease questionnaire (QoL-AD) between baseline and 3 month follow-up. A secondary outcome measure of staff satisfaction was also assessed.

The economic evaluation was conducted from a societal perspective. Costs were assigned to all resources used as a consequence of the intervention and compared to any change in the care as usual group. There are three major cost components to the economic evaluation – (A) the cost associated with delivery and attendance by staff to the intervention training and support (where applicable); (B) cost of replacement staff for sick leave (nominally taken as the week prior to collection of data) and (C) Cost of assistance from family/friends of the resident(s). Resource information and the associated costs were collected on the intervention project management (facilitator time and handouts, etc. needed to deliver the training); staff time to attend the training as well as changes to staff allocated hours (replacement for sick leave), resources used by residential aged care facility (RACF) used (e.g. use of private physiotherapist); and also informal care time contributed to residents by family members and/or friends (assistance from family and/or friends). The reference year used for all costs was 2016.

Information on RACF resource use was collected from the facility site Resource Use Questionnaires (Appendix 6) at baseline and 3 month follow-up. Management staff completed questionnaires which included information on the number of permanent staff, replacement staff (for sick leave in the week prior to the data collection point) and number of residents within the facility and the Unit participating in the intervention (where applicable).

Measured staff replacement costs were valued using the 'Catholic Healthcare Residential Aged Care Enterprise Agreement (NSW) 2015-2018". The Enterprise Agreement provided staff costings for each of the different staff levels measured within the facility Resource Use Questionnaires. It also provided information on allowances and casual wage rates. Although the Enterprise Agreement was based in NSW, of the resources available online this agreement provided the most comprehensive and consistent staff costings in 2016 dollars. Table 20 lists the cost per hour by staff type, time of day and whether they were casual or full-time. Each replacement staff member was only assumed to have worked a minimum 4 hour shift.

Table 20. Replacement Staff Unit Costs (Hourly rate of replacing staff if they 'called in sick')

	Staff Unit Costs (hourly rate)					
	Mon-Fri	AM	PM	Night	Sat	Sun
Personal Care Attendant	$21.09	$21.09	$23.73	$24.25		
Casual Assistant in Nursing	$26.36	$26.36	$29.66	$30.32	$31.64	$36.91
Enrolled Nurse	$27.14	$27.14	$30.53	$31.21		
Casual Enrolled Nurse	$33.92	$33.92	$38.16	$39.01	$40.70	$47.49
Registered Nurse	$34.11	$34.11	$38.38	$39.23		
Casual Registered Nurse	$42.64	$47.97	$42.64	$49.04	$51.17	$59.70
Care Service Employee	$23.42	$23.42	$26.35	$26.93		
Casual Care Service Employee	$29.27	$29.27	$32.93	$33.66	$35.13	$40.98
Catering Assistant	$21.97	$21.97	$24.72	$25.27		
Casual Catering Assistant	$27.46	$27.46	$30.90	$31.58	$32.96	$38.45
Laundry Services Assistant	$19.00					
Cleaning Services Attendant	$19.00					

Pro rata costs of management staff to attend the training had been determined in an ad-hoc manner by the Trial Investigators prior to commencement of the study (Table 21).

Table 21. Unit Costs relating to the delivery (by the Facilitator) and staff attendance of the Intervention (Hourly rate of pay)

	Salary: Unit costings (hourly rate)		Number of staff attending of training per 100 resident facility[1]
Facilitator	Per hour	$ 45.00	1
Management Staff	Per hour	$ 70.00	5
Registered Nurse	Per hour	$ 35.00	5
Personal Care Attendant	Per hour	$ 20.00	10
Miscellaneous Unit costs			
Cost Per A4 Sheet Paper	$ 0.05		
Facilitator Standard Cost per Return Trip to the facility	$ 50.00		

1 For balanced comparisons between intervention groups we assumed that each facility had 100 residents and that the training and intervention was delivered to 5 staff at a managerial level; 5 staff equivalent to Registered nurse and 10 staff paid at the level of Personal Care Assistant (PCA).

The third and final costings included within the analysis was the assisted time for residents provided by family and friends. A question on the amount of informal care time contributed by family members and/or friends was included with the resident survey at baseline and follow-up. This has been costed as the average wage rate plus on costs ($49.87) and multiplied by 25%.[20] A common convention is to value such leisure time at 25% of the wage rate. The mean average assisted hours at baseline and follow up are listed in Table 22.

Table 22. Assisted Hours and Costs of support from Family and Friends: Baseline and Follow-Up

	n	Mean hours per resident	SD (hours)	Mean cost per resident ($)	[95% Confidence Interval] of cost
Training + support					
Baseline[1]	8	0.5	0.38		
Follow-up	8	2.5	1.39	$31.17	-$7.43 - $69.77
Training					
Baseline[1]	12	0.69	0.30		
Follow-up	12	0.84	0.84	$1.04	-$1.25 – $3.23
Care as usual					
Baseline[1]	12	1.5	0.59		
Follow-up	12	1.38	0.84	$17.14	-$5.84 – $40.12

1 Baseline replacement costs not used but are presented for comparison with the follow-up staff replacement costs.

Measure of Effectiveness

The primary outcome measure of effectiveness used within the RCC program was the QoL-AD. The QoL-AD is a valid HRQOL instrument for use with people with mild to moderate dementia.21 It contains 13 items and each item is rated on a four-point scale 1= poor and 4=excellent. An adaption with 15 items had been developed for use in long-term care facilities and has been applied within this study. For each participant, an aggregate score was used by summing the scores of items 1 to 15. Each item was given equal weighting so the range of possible scores was 15 to 60.

Health economic studies will often utilise Quality Adjusted Life Years (QALYs) to measure changes in health effects as it allows for comparison between interventions when clinical outcomes are not directly comparable. A QALY is calculated based on a health-related quality of life (HRQOL) measure and a preference score is then generated on a scale of 0 (death) to 1 (full health). A willingness to pay threshold of $50,000 per QALY is typically applied in Australian health economic evaluation literature.22-23

The QoL-AD does not allow for the calculation of a QALY. An Australian study is developing a new health state classification system from the QoL-AD to allow calculation of a QALY but this is only in its early stages.24 At this time the economic evaluation can only be compared with other studies also using QoL-AD, analysed from a societal perspective.

Economic Evaluation: Incremental Cost Effectiveness Ratio

The results of the economic evaluation for the Resident at the Centre of Care (RCC) program are expressed as incremental cost effectiveness ratios (ICER). The ICER is the change in costs of the intervention compared to current practice, to the change of effects of the intervention compared to current practice.

The ICERs that have been calculated from this evaluation are based on a one unit increase in the QoL-AD measurement. The minimum score an individual can record is 15 and the largest is 60. The ICER has been calculated as the difference in mean cost per resident in the training only group and the care as usual group divided by the difference in QoL-AD score between the two groups. This calculation is repeated for comparison between the training + support group and the care as usual group.

$$\text{ICER} = \frac{\text{Cost}_{\text{intervention}} - \text{Cost}_{\text{comparator}}}{\text{Effectiveness}_{\text{intervention}} - \text{Effectiveness}_{\text{comparator}}}$$

Results

The economic evaluation included the same study population as the main pilot trial. Table 23 provides a summary of the characteristics of the participants for each of the 3 groups (2 intervention groups plus care as usual group).

Table 23. Resident participant characteristics and follow-up QoL-AD results

Measures1	Training + support *n=8*	Training *n=12*	Care as usual *n=12*
Total number of residents in the facility	N=110	N=109	N=64
Total number of residents in the unit	N=38	N=109	N=64
Demographics			
Male (%)	38%	25%	58%
Age, Year	84.3 (4.7)	82.3 (7.8)	82.8 (9.3)
Health			
QoL-AD Baseline	36.9 (4.5)	44.9 (5.9)	42.8 (7.1)
QoL-AD Follow Up	40.4 (6.1)	48.8 (6.9)	42.7 (7.3)
QoL Difference Follow-up - Baseline	3.5	3.9	-0.1

1 N = refers to the number of residents participating in the study and who completed the QoL-AD at both baseline and follow-up

Intervention Costs

Although only a small proportion of residents from each facility participated in the RCC program it was assumed that after the staff were trained, the facility would be organised as a consumer directed care facility and all residents in the facility would have the choice of consumer-directed care initiatives associated with the program. For this reason the cost of the intervention has been divided by the total number of residents in the entire facility and not just those taking part.

The total intervention cost per resident for training + support compared to training only was $497 versus $163 respectively. The intervention costings included the cost of facilitator training and travel time, costs of staff training time and completion of homework tasks as well as the cost of the equipment and resources used to administer the training. Different levels of staff (e.g. managers, personal care assistants) participated in the training programs. For this pilot study, facilitator travel time was included as a standard $50 per return trip to the facility.

Table 24 lists the cost inputs used with the intervention costings.

Table 24. Mean Cost per Resident by Intervention Group*

	Total Cost Per Resident				
	Cost A*	**Cost B***	**Cost C***	**Cost (A+B+C)**	**[95% Confidence Interval]**
Training + support	437.69	31.17	27.98	$496.84	$458.24 - $535.44
Training	142.24	1.04	19.93	$163.21	$160.92 - $165.50
Care as usual	n/a	17.14	23.45	$40.59	$17.61 - $63.57

*Total of (A) intervention program costs; (B) cost of assisted hours by family/ friends (C) cost of replacement staff (sick leave)

Cost per Resident

The 'resource use' questionnaires completed at follow-up for all three groups included changes from baseline for staff costs relating both to time in attending the training and any subsequent duty shift changes that required staff replacement. Tables 20 and 25 show the staff hourly pay rate used to calculate incremental cost changes between baseline and 3-month follow-up. Table 21 presents the unit costs applied for each component of the intervention.

Table 25. Total cost of replacement staff expressed as a per resident (for a one week period)[1]

	Baseline[2]	Follow Up
Training + Support	$ 10.05	$ 27.98
Training	$ 10.21	$ 19.93
Care as usual	$ 35.18	$ 23.45

1 The facilities provided the number and level of staff that needed to be replaced in the week prior to the data collection point. The information given related either to the replacement staff within the Unit or the replacement staff for the entire facility. The total costings of these replacement staff was then divided by the number of residents in the Unit or in the entire facility, as applicable.

2 Baseline replacement costs not used but are presented for comparison with the follow-up staff replacement costs.

Table 26 lists the mean assisted hours provided by family members and friends to residents. Assisted hours remained similar between baseline and follow up for the training only and care as usual groups. The training + support intervention had a mean increase from 0.41 to 2.5 hours per resident per week.

Table 26. Assisted Hours and Costs of support from Family and Friends: Baseline and Follow-Up

	n	Mean hours per resident	SD (hours)	Mean cost per resident ($)	[95% Confidence Interval] of cost
Training + support					
Baseline1	8	0.5	0.38		
Follow-up	8	2.5	1.39	$31.17	-$7.43 - $69.77
Training					
Baseline1	12	0.69	0.30		
Follow-up	12	0.84	0.84	$1.04	-$1.25 – $3.23
Care as usual					
Baseline1	12	1.5	0.59		
Follow-up	12	1.38	0.84	$17.14	-$5.84 – $40.12

[1] Baseline replacement costs not used but are presented for comparison with the follow-up staff replacement costs.

Across the three facilities a total of 32 residents completed both the baseline and follow-up questionnaire. *Training and support* consisted of 8 participant residents while the *training only* and *care as usual* groups each had 12 participant residents. The mean cost per resident by intervention group is shown in Table 27. As expected, the *training + support* group ($497) have substantially higher intervention costs due to the extra time (and consequently, salary cost) devoted to the additional organisational support compared to the *training only* group ($163). The *care as usual* group had a mean change in cost per resident of $41 due to the cost of replacement staff for sick leave and assisted time from family and friends.

Table 27. Costs relating to the delivery (by the Facilitator) and staff attendance of the Intervention Program

	Training + support	Training	Care as usual
Material Cost	$161.00	$161.00	-
Cost of Facilitator Travel	$1250.00	$500.00	-
Facilitator set-up time cost	$288.75	$101.25	-
Facilitator pack-up time cost	$288.75	$236.25	-
Facilitator Training Session Cost	$2,992.50	$900.00	-
Management Staff Session Cost	$16,975.00	$4,200.00	-
Nurse Staff Session Cost	$8,487.50	$2,100.00	-
PCA Staff Session Cost	$9,700.00	$2,400.00	-
Costs to Complete Homework1	$3,625.00	$3,625.00	-
Total Cost	$43,768.50	$14,223.50	-
Cost Per Resident2	$437.69	$142.24	-

1The homework tasks were the same for the 2 intervention groups and the time to complete homework has been taken as the mean of the two groups since homework was completed prior to the organisational support.

2Training + support facility had a total of 110 residents and training only facility had 109 residents. For staff and Facilitator time and salary during delivery of the intervention, the number of residents per facility has been set as 100 residents per group for all groups. This gives a balanced comparison between groups when quoting cost per resident as the number of staff and Facilitator delivering and attending the program would not vary where the total residents were approximately 100.

Quality of Life Difference

QoL-AD difference was calculated by subtracting the QoL-AD score at baseline from the follow up score. The results are listed in Table 28. A positive difference (improved QoL) was observed in both the training + support group (3.5) as well as the training only group (3.9). No change was seen in the care as usual group.

Table 28. QoL-AD Difference between Baseline and Follow-up by Intervention Group

	n	Mean diff.	[95% Confidence Interval]
Training + Support	8	3.5	-2.3 - 9.3
Training	12	3.9	0.1 – 7.7
Care as usual	12	-0.1	-5.6– 5.3

Incremental Cost Effectiveness Ratios

RCC Training + Support vs Current Practice (care as usual group):

$$\text{ICER} = \frac{496.84 - 40.59}{3.51 - (-0.15)}$$

For the training + support group the cost per one point increase in QoL-AD measure per resident is $124.66.

RCC Training Only vs Current Practice (*care as usual* group):

$$\text{ICER} = \frac{163.21 - 40.59}{3.89 - (-0.15)}$$

For the training only the cost per one point increase in QoL-AD measure per resident is $30.35.

DISCUSSION

The Resident at the Centre of Care (RCC) Program was designed to equip staff with the skills to develop a CDC model of care that would work for their particular facility, taking into account the nature of the residents, staffing and organisational structure. It focussed on enhancing the communication between staff and residents so that residents were empowered to indicate how they would like to live their lives in the RACF; that is, to ensure that they drove the nature of their care. It also focussed on overcoming the barriers to CDC and build the enablers or facilitators, in terms of both staff attitudes and behaviours as well as the function of the organisation. In this way, the program focussed on both transformational leadership and a range of organisational factors that are central to ensuring that staff have the skills and motivation to implement a CDC model of care.

So did the RCC Program Work?

This discussion will report on the barriers and enablers to CDC, as perceived by staff. It will then examine changes in the residents' wellbeing, staff feelings about their work, changes to organisational practice and, finally, the economic evaluation of the CDC model that was implemented. The implications of these findings for policy and practice will then be considered, followed by limitations of the current study and directions for future research.

Barriers and Enablers

Staff identified a range of organisational factors that were both barriers and enablers to the implementation of CDC. Most particularly, the hierarchical structure of RACFs and so staff resistance to implementing change, as well as staff shortages and a lack of funding to support change were highlighted. Communication among staff and a lack of knowledge of the expectations of residents and their families were also highlighted. In relation to enablers, staff highlighted open and honest communication within the team, management support for initiatives, team meetings and support from families as being important factors that facilitated the implementation of CDC. The program was designed for staff to work with these factors to assist them in the implementation of CDC in their facility.

Resident Measures

There were mixed findings in relation to the extent to which residents in the two training conditions demonstrated increased satisfaction with their care after the program was completed. This may have been due to resident confusion about their choice – they may have had limited choice around their care in the past and so engaging in the process of having more choice may have highlighted their levels of dissatisfaction. In future, prior to the implementation of the CDC model, there needs to be a greater focus on the development of the communication between staff and residents, particularly around familiarising residents with the potential for choice that they have in the nature of their care.

In most of the other areas of resident wellbeing, there were improvements in both training groups at the conclusion of the program, with the training + support group generally demonstrating most improvement. There were improvements in quality of life, perceptions of greater choice in the residents' care, closer working relationships with staff, greater connections with others and improved feelings of competence and autonomy. These changes are quite significant, particularly given the potentially disruptive nature that change may bring to residents' lives in the short term, and the fact that this information was gathered only 12 weeks after the completion of staff training. One would expect that as the implementation of resident choice in the Resident Care Form was in place for a longer period of time, there would be further enhancement of residents' positive feelings about being in control of their care as well as other aspects of their wellbeing.

Staff Measures

The senior staff were more likely than general staff to report positive outcomes to these measures, but overall the findings were not as positive as we expected. The training + support group reported the most positive findings, perhaps due to the extra assistance that they obtained to implement the CDC model of care. However, it is important to remember that the implementation of CDC practices brought about significant changes in the work roles of staff, in the way in which they worked with residents and one another, as well as the way in which the

RACF was organised. These changes are difficult to accommodate over a short period of time (the final data collection was only 12 weeks after the training) among staff who are already stretched in terms of the time they have available to do their work. At each of the training sites there were also significant changes in the broader work environment. In the training + support site, there was a change in senior management, with the new manager not being aware of the RCC program, and so there was a reduction in the momentum to implement the CDC program. In the training only site, multiple staff, including senior staff, were made redundant midway through the program. This may well have impacted on the extent to which staff felt supported by the organisation.

Organisational Factors

General staff in the training groups did not indicate positive changes in the organisational factors at the conclusion of the program or at follow-up. This may well have been due to the factors outlined above: the short timeline after the completion of the program and external organisational factors. However, senior staff in the training + support program demonstrated positive changes in relation to their perceptions of their sense of autonomy support, trust, cohesion and recognition. It is possible that the extra support they received from research staff in implementing CDC over the 12 weeks after the training was completed facilitated these positive feelings about the organisation, as well as the sense of collaboration between staff members.

Economic Evaluation

The principal findings from this pilot study show that the improvement in QoL-AD was similar in the training + support and the training only groups and the cost per one point improvement in the QoL-AD is lower in the training only group ($125 vs $30, respectively). However due to the short intervention period, the cost of the additional staff time in the group that received organisational support is a major driver of the extra cost per resident in the training + support group. If the observation period had extended further past the completion of the intervention, this staff cost may have been off-set by few staff replacement costs. Alternatively the organisational support may improve residents' quality of life with a smoother transition to the consumer directed care model. The costing period finished at the completion of the group with the longest intervention period (training + support). Due to the short duration of data collection and low resident participant numbers, we are unable to statistically test for differences between the groups.

The main cost drivers within the two interventions can be attributed to management attendance in the program. Each hour of attendance by management staff has an associated cost of $70. Management staff made up the majority of staff members taking part in the program training sessions. To ensure a fair comparison of costs despite having only one facility per intervention and care as usual group, the calculations are based on an equal number of managers, registered nurses and personal care assistants participating in the two intervention groups (5 managers; 5 nurses and 10 personal care assistants per 100 residents in a facility).

The two intervention groups both reported little change in resource use (e.g. use of private providers such as physiotherapists) other than staff time to attend training, and support (if applicable) during the intervention period of consumer directed care. All facility site managers reported no change in the number and/or type of permanent staff employed in the past 3 months. The only costings collected from the resource use questionnaire completed by managers at follow-up, were the replacement (sick leave) staff employed at the facility in the past week.

Information was collected on whether facilities had purchased or leased new equipment during the study timeframe. These costs were not included within the analysis as it could not be determined if in fact these changes could be attributed to the RCC program. One site had leased a bed mattress costing $565 a month.

DISCUSSION CONTINUED

Limitations

This evaluation was only completed across three facilities. Clearly a wider evaluation with a greater range of facilities is required. The team have applied for funding to implement and evaluate the RCC program in 39 RACFs in Queensland, New South Wales and Victoria. The number of participants (both residents and staff) in the facilities in the current study was lower than planned. In this initial trial, we have learnt strategies to ensure that we both recruit and retain a greater number of participants. There needs to be more time spent in building the working alliance between staff and residents. In this way, residents feel greater empowerment to actually express their desire for change in both their care needs as well as their daily activities. Finally, there is a need for a longer follow-up period to determine the effectiveness of the training for residents, staff and organisational measures. One would expect that after 12 months, there would be time to actually operationalise the training and the benefits to the residents, staff, as well as the overall functioning of the RACF would be more apparent.

A major limitation of this study and pilot studies more generally, is the small study sample and short time-frame. The economic analysis has been based on 32 residents spread across the three groups. As a result, large variability exists in the incremental cost effectiveness ratios generated due to the small sample size. Significant variability was also attributable to the low number of facilities enrolled in the pilot study – a total of three facilities so only one facility per intervention group.

The timing of the intervention is also likely to have had an impact on its overall effectiveness. The training program concluded just prior to Christmas. This meant that the follow-up period ran over Christmas, when many staff were on extended periods of leave (particularly key senior staff). The overall effectiveness of the two training programs is likely to have been influenced. Implementation of future RCC training sessions should occur when staff leave is at a minimal.

All facilities were participating in a number of other projects and training sessions at the same time as the consumer directed care project. Many staff reported feeling “over-researched”. It is difficult to measure the impact this would have had on the RCC program.

A general limitation of this study is its comparability to other studies. These results are comparable against other studies which have utilised the QoL-AD but it is difficult to put into real terms what is the impact of a one point increase in QoL-AD (score range is 15 to 60). In the future this study would be strengthened by including a quality of life measurement that is able to calculate a QALY. Currently however no quality of life measurement exists that is able to generate a QALY if the individual is suffering from early stages of Alzheimer’s. The EQ-5D has been cited as the most appropriate quality of life measurement in the elderly although it too has significant weaknesses [6].

Resource use questionnaires were completed by facility managers on behalf of the entire facility. This meant that any small change in staff levels as a result of the intervention were measured across the entire facility and not just those providing care to residents. This has made it difficult to measure the true effectiveness of the intervention. For example the change in replacement staff were measured across a facility size of 100 residents of which few residents were taking part in the intervention. If less replacement staff were being utilised as a result of the RCC program this effect was only able to be measured as a proportion of the total staffing level across either a particular unit or the entire facility.

Implications for Practice and Policy

The results from this study demonstrate that the RCC Program was effective in improving residents' sense of wellbeing. These were some improvements in staff and organisational measures, but it is likely that a longer follow-up time is needed before staff settle into their new work role and this flows over to their more positive perceptions of the workplace. The findings indicate the importance of staff training in organisational change, as well as CDC strategies, if the process of change is to occur. Knowledge of CDC on its own is unlikely to be effective. Translation of training into practice is essential if CDC is to be adopted. This will involve addressing the barriers to the implementation of CDC as well as utilising and fostering the enablers of CDC. It is important that a working alliance is formed with each resident. Residents are unlikely to feel confident in sharing their care needs when they have a strong sense that the staff will structure their care so that their needs can be met. In addition, changes need to be made to the dynamics of the work environment of both general staff as well as management: communication, trust, empowerment, recognition, autonomy, as well as the actual job role of staff.

Conducting an economic evaluation within the pilot study stage of the RCC program provides researchers with important information before a full economic evaluation is undertaken. Thanks to this evaluation improvements in the data collection process will be implemented. A number of questions included in the facility resource use questionnaire have proven to be irrelevant at three month follow-up. Any resource use questionnaire in the future must make better use of the facility managers' time and ask questions that will enable costings to be able to be generated. Debate should be encouraged on what questions and costings to include in future RCC study questionnaires.

This evaluation has provided information on the main cost drivers for the RCC intervention. Including management staff in the training and support sessions adds significant costs to the program. Further research is required to determine whether the benefit of including management staff and their high associated cost is worthwhile. Asking residents whether they required assistance from family members or friends provided an additional source of costings to include within the analysis. Generally however residents responded "no" to requiring assistance.

The findings from the current study certainly suggest that CDC can have a positive impact on both resident and the staff, and so needs to be implemented into RACFs. Training and support for residents, families and staff is necessary to assist in this process.

The RCC program has been effective in increasing aged care residents quality of life as measured by the QoL-AD. Improvements were seen in both the training + support group and training only. The economic evaluation was not able to determine if the increased cost of providing support with training is justified in the longer follow-up time after training and support (and extra associated costs of support training). Future studies require improved costing information to more competently assess the cost-effectiveness of the RCC program.

The real value of this study has been to demonstrate that a CDC model of care, as presented in our RCC program, leads to positive outcomes and is cost effective. Clearly further work is necessary to refine both the training program and model of care. Further work is also necessary to empower both residents and their family to recognise that the can and should request the type of care and activities that suit their needs. There is still a distance to go in terms of determining the ideal way to achieve CDC in RACFs. However, the RCC program has been shown to be a very effective first step in this direction.

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Appendices

Appendix A: Resident Care Form

Appendix B: Barriers & Enablers worksheet

Appendix C: Resident survey

Appendix D: Staff survey

Appendix E: Resource Use Questionnaire (Economic Evaluation)

Appendix F: Program Feedback form

APPENDICES

APPENDIX A

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RESIDENT CARE FORM

RESIDENT CARE FORM

Resident name:	
DOB:	
Room No:	
Staff name:	
Date completed:	

Staff Instructions

During administration of the Resident Care form, it is crucial that you collaborate with the residents to reach mutually agreed upon (1) care-related goals, and (2) care-related tasks that suit the needs and preferences of the residents.

For each care and leisure task, there are a series of common questions relating to when, how and by whom the resident would like their care and leisure tasks to be conducted. The form also asks whether the resident would like to make any changes to the way tasks are performed.

Please record specific details about resident care preferences in the "Staff and Resident Comments" section for each care or leisure task. You may also make other comments from the residents, or your own thoughts or observations. Please ensure it is clear which comments are the resident's and which are your own.

When and how should the Resident Care Form be completed?

1. The care form can be completed over a period of seven days (a little at a time) and should be completed at times that are best for the resident.
2. Complete one section at a time, either around the time or during the related task you are attending to. Completing the care form 'in context' will assist the resident to orient to the care form and respond to your questions.
3. For each task, make a note of their current care needs and other relevant information prior to completing the form with the resident. Ensure that you check whether the resident agrees with the information about their care needs (particularly level of independence). If the resident disagrees, ask them why and note their response under "Staff and Resident Comments".
4. NOTE: In order to honour and respect the resident, it is important not to try to argue with the resident about their care needs and level of independence. Instead, accept their differing opinion (regardless of accuracy) and make a note under "Staff and Resident Comments".

When using the Resident Care Form, please ensure you:

1. Assist the resident to complete the form and encourage them to take as much control as possible.
2. Ask the resident if they would like to fill out the form themselves. Reassure them that the staff member (and family member, if applicable) will guide them through the form.
3. Check that the resident understands, agree with, and is satisfied with each care and leisure task as detailed in the form.
4. At regular intervals, check that the resident is alert and oriented to the task. Remain alert to the resident's level of fatigue (mental or physical) throughout the process. If the residents appear tired, or if they are unable to continue for any reason, please ask the resident if they would like to stop and offer to continue at another time.
5. For each task, you will ask the resident whether there is anything they would like to change about that task. Once they answer "yes" or "no", ensure you gather further detail to record in the comments section. Some example prompts include:
   - "Is there anything you would like to change about when we help you with this task?"
   - "Is there anything you would change about how we help you?"
   - "Who do you like to help you with this task?"

WAKE UP & BED TIME

Assistance	Current time		Preferred time		Preferred staff member(s)
	Wake up	**Bed time**	**Wake up**	**Bed time**	
☐ Help waking up	☐ Before breakfast	☐ Between 7-8pm	☐ Before breakfast	☐ Between 7-8pm	Name:
☐ Help preparing for bed	☐ After breakfast	☐ Between 8-9pm	☐ After breakfast	☐ Between 8-9pm	
☐ Independent	☐ Late morning	☐ Between 9-10pm	☐ Late morning	☐ Between 9-10pm	
	☐ Other time:	☐ Other time:	☐ Any time	☐ Any time	Position:
			☐ Other time:	☐ Other time:	

I am happy with how and when staff wake me up:	✓ Yes	✗ No
I am happy with how and when staff help me prepare for bed:	✓ Yes	✗ No
Is there anything you would like to change about waking up or going to bed?	✓ Yes	✗ No

Staff & resident comments: *E.g. consider how the resident prefers to be woken (or not) in the morning; items for comfort or safety*

DRESSING

Assistance	Current time		Preferred time		Preferred staff member(s)
	Wake up	**Bed time**	**Wake up**	**Bed time**	
☐ Full assistance	☐ Before breakfast	☐ Between 7-8pm	☐ Before breakfast	☐ Between 7-8pm	Name:
☐ Supervision	☐ After breakfast	☐ Between 8-9pm	☐ After breakfast	☐ Between 8-9pm	
☐ Help setting up	☐ Late morning	☐ Between 9-10pm	☐ Late morning	☐ Between 9-10pm	
☐ Independent	☐ Other time:	☐ Other time:	☐ Any time	☐ Any time	Position:
			☐ Other time:	☐ Other time:	

I agree with this description of my needs for dressing:	✓ Yes	✗ No
I am happy with the way staff help me dress:	✓ Yes	✗ No
Is there anything you would like to change about how staff help you dress?	✓ Yes	✗ No

Staff & resident comments:

BATHING

Assistance	Current days	Preferred days	Current time	Preferred time	Preferred staff member(s)
☐ Full assistance ☐ Supervision ☐ Independent	☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday	☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday ☐ Any day	☐ Before breakfast ☐ After breakfast ☐ Late morning ☐ Before dinner ☐ After dinner ☐ Before bed ☐ Other time	☐ Before breakfast ☐ After breakfast ☐ Late morning ☐ Before dinner ☐ After dinner ☐ Before bed ☐ Other time	Name: Position:

Equipment:		Hair washed		Any other known requirements?
☐ Sponge wash ☐ Pull down bench	☐ Shower chair ☐ Other:	☐ Staff ☐ Hairdresser	☐ Daily ☐ 2nd/3rd day ☐ Weekly	

I agree with this description of my needs for bathing:	✓ Yes	✗ No
I am happy with the way staff help me bathe:	✓ Yes	✗ No
Is there anything you would like to change about how staff help you bathe?	✓ Yes	✗ No

Staff & resident comments: *E.g. consider how the resident prefers to be woken (or not) in the morning; items for comfort or safety*

GROOMING (e.g. brushing teeth, combing hair, shaving)

Assistance	Current time		Preferred time		Preferred staff member(s)
	Wake up	**Bed time**	**Wake up**	**Bed time**	
☐ Full assistance	☐ Before breakfast	☐ Between 7-8pm	☐ Before breakfast	☐ Between 7-8pm	Name:
☐ Supervision	☐ After breakfast	☐ Between 8-9pm	☐ After breakfast	☐ Between 8-9pm	
☐ Help setting up	☐ Late morning	☐ Between 9-10pm	☐ Late morning	☐ Between 9-10pm	
☐ Independent	☐ Other time:	☐ Other time:	☐ Any time	☐ Any time	Position:
			☐ Other time:	☐ Other time:	

Any other known requirements?		
I agree with this description of my needs for grooming:	✓ Yes	✗ No
I am happy with the way staff help me with grooming:	✓ Yes	✗ No
Is there anything you would like to change about how staff help you with grooming?	✓ Yes	✗ No

Staff & resident comments:

PAMPERING & BEAUTY

Assistance	Current days	Preferred days	Current time	Preferred time	Preferred staff member(s)
☐ Hairdressing					
☐ Manicure					Name:
☐ Pedicure					
☐ Facial					
☐ Massage					Position:
☐ Hair removal					
☐ Other:					

I agree with this description of my pampering and beauty needs:	✓ Yes	✗ No
I am happy with the way staff help me with my pampering and beauty needs:	✓ Yes	✗ No
Is there anything you would like to change about how staff help you with your pampering and beauty needs?	✓ Yes	✗ No

Staff & resident comments:

SKIN CARE

Assistance	Current frequency	Preferred frequency	Current time(s)	Preferred time(s)	Preferred staff member(s)
☐ **Bandage or wound dressing**	☐ Daily	☐ Daily			
☐ Full assistance	☐ 2nd/3rd day	☐ 2nd/3rd day			
☐ Help setting up	☐ Weekly	☐ Weekly			
☐ Supervision	☐ Fortnightly	☐ Fortnightly			
☐ Independent	☐ Other:	☐ Other:			
☐ **Skin emollients**	☐ Daily	☐ Daily			
☐ Full assistance	☐ 2nd/3rd day	☐ 2nd/3rd day			
☐ Help setting up	☐ Weekly	☐ Weekly			
☐ Supervision	☐ Fortnightly	☐ Fortnightly			
☐ Independent	☐ Other:	☐ Other:			

I agree with this description of my skin care needs:	✓ Yes	✗ No
I am happy with the way staff help me with my skin care needs:	✓ Yes	✗ No
Is there anything you would like to change about how staff help you with your skin care needs?	✓ Yes	✗ No

Staff & resident comments:

TOILETING

Assistance	Bladder needs	Bowel needs	Preferred staff member(s)
☐ Full assistance	☐ Incontinent	☐ Incontinent	Name:
☐ Some help but can do some thing(s) themselves	☐ Uses bed pan	☐ Uses bed pan	
☐ Supervision	☐ Continence pad	☐ Continence pad	
☐ Independent	☐ Catheter	☐ Enemas	Position:

I agree with this description of my toileting needs:	✓ Yes	✗ No
I am happy with the time of day staff help me with my toileting needs:	✓ Yes	✗ No
Is there anything you would like to change about how staff help with your toileting needs?	✓ Yes	✗ No

Staff & resident comments:

TRANSFERS (between bed & chair)

Assistance	Current time	Preferred time	Mobility	Preferred staff member(s)
☐ Full assistance	☐ Before breakfast	☐ Before breakfast	☐ Immobile or < 45 metres	
☐ Lifting machine	☐ After breakfast	☐ After breakfast	☐ Wheelchair independent, including corners, > 45 metres	Name:
☐ Slide sheet	☐ Late morning	☐ Late morning	☐ Walks with help of 1 person (verbal or physical) > 45 metres Position:	
☐ Physical assistance (1 or 2 staff)	☐ Before dinner	☐ Before dinner	☐ Independent (but may use aid, e.g. walking stick) < 45 metres	
☐ Physical prompting	☐ After dinner	☐ After dinner		
☐ Verbal prompting	☐ Before bed	☐ Before bed		
	☐ Other time	☐ Other time		

I agree with this description of my needs for assistance with moving around and getting in and/or out of bed or a chair:	✓ Yes	✗ No
I am happy with the way staff help me to move around and get in and/or out of bed or a chair:	✓ Yes	✗ No
Is there anything you would like to change about how staff help you move around and get in or out of bed or a chair?	✓ Yes	✗ No

Staff & resident comments:

PAIN MANAGEMENT

	Current frequency	Preferred frequency	Current day/time	Preferred day/time	Preferred staff member(s)
☐ Massage					
☐ Shoulders ☐ Feet/legs					Name:
☐ Neck ☐ Hands/ arms					
☐ Back ☐ Other:					
					Position:
☐ Heat or cold pack					
☐ Ointment					
☐ Repositioning					Name:
☐ Medication					
☐ Full assistance					
☐ Supervision					Position:
☐ Independent					

I agree with this description of my pain management needs:	✓ Yes	✗ No
I am happy with the way staff help me with my pain management needs:	✓ Yes	✗ No
Is there anything you would like to change about how staff help with your pain management needs?	✓ Yes	✗ No

Staff & resident comments:

EATING & DRINKING

Assistance	Meal	Current time	Preferred time	Preferred staff member(s)
☐ Full assistance	☐ Breakfast	**Wake up**	**Bed time**	
☐ Supervision	☐ Morning tea	☐ Before breakfast	☐ Between 7-8pm	Name:
☐ Help setting up	☐ Lunch	☐ After breakfast	☐ Between 8-9pm	
☐ Independent	☐ Afternoon tea	☐ Late morning	☐ Between 9-10pm	
☐Modified diet (specify):	☐ Dinner	☐ Any time	☐ Any time	Position:
	☐ Other:	Independent	☐ Other time:	
Any other known requirements?				

I agree with this description of my meal time needs:	✓ Yes	✗ No
I am happy with the way staff help me with meals:	✓ Yes	✗ No
Is there anything you would like to change about how staff help you with your meals?	✓ Yes	✗ No

Staff & resident comments:

MEAL CHOICES

Breakfast		Afternoon tea	
☐ Facility provided	Where I eat:	☐ Facility provided	Where I eat:
☐ Own/family provided	Who I eat with:	☐ Own/family provided	Who I eat with:
	Preferred meal:	☐ N/A	Preferred meal:

Morning tea		Dinner	
☐ Facility provided	Where I eat:	☐ Facility provided	Where I eat:
☐ Own/family provided	Who I eat with:	☐ Own/family provided	Who I eat with:
☐ N/A	Preferred meal:	☐ N/A	Preferred meal:

Lunch		Alcohol		
☐ Facility provided	Where I eat:	☐ Nil	☐ Beer	**Time/meal:**
☐ Own/family provided	Who I eat with:	☐ Wine – red	☐ Bourbon	
	Preferred meal:	☐ Wine – white	☐ Scotch	
		☐ Other:		

I am happy with the foods and drinks we have here:	✓ Yes	✗ No
Is there anything you would like to change about the food and drinks we have here?	✓ Yes	✗ No

Staff & resident comments:

SOCIAL & LIFESTYLE ACTIVITIES

Activities	Top 3	Preferred frequency	Preferred day	Preferred time	Preferred staff
☐ Personal development course					
☐ Word games/puzzles					
☐ Jigsaw puzzles					
☐ Ball games					
☐ Art & craft					
☐ Men's Shed					
☐ Footy tipping					
☐ Pet therapy					
☐ Gardening					
☐ Cooking					
☐ Singing					
☐ Church/religious service					
☐ Knitting					
☐ Exercise/walking					
☐ Family outing					
☐ Discussion group					
☐ Other:					

I am happy with the activities and social life here:	✓ Yes	✗ No
Is there anything you would like to change about your activities or social life here?	✓ Yes	✗ No

Staff & resident comments:

COMMUNICATION & RELATIONSHIPS

I enjoy talking to others:	✓ Yes	✗ No
I have enough people to talk to:	✓ Yes	✗ No
I like to talk to other residents:	✓ Yes	✗ No
I like to talk to staff:	✓ Yes	✗ No
I would like more opportunity to talk to others:	✓ Yes	✗ No
Is there anything you would like to change about who you talk to or the conversations you have?	✓ Yes	✗ No

Staff & resident comments:

Communication & technology

- ☐ Mobile phone
- ☐ Skype
- ☐ iPad/tablet
- ☐ Computer/laptop

Tick those that the resident would like access to

MEDICAL & ALLIED HEALTH SERVICES

Service	Current frequency	Preferred frequency	Current time(s)	Preferred time(s)
☐ General Practitioner (GP)				
☐ Geriatrician				
☐ Optometrist				
☐ Audiologist				
☐ Physiotherapist				
☐ Speech Pathologist				
☐ Occupational Therapist				
☐ Podiatrist				
☐ Dentist				
☐ Dietician				
☐ Social Worker				
☐ Counsellor				
☐ Other:				

I am happy with the services I currently receive:	✓ Yes	✗ No
I know enough about the different services I could receive (if I wanted to):	✓ Yes	✗ No
Is there anything you would like to change about the services you receive?	✓ Yes	✗ No

☐ **Staff & resident comments:**

APPENDIX B

—

BARRIERS & ENABLERS WORKSHEET

HANDOUT 1.1: BARRIER & ENABLERS WORKSHEET

a) Staff members' sense of autonomy and responsibility in the work place

Barriers	Strategies to overcome challenges	Enablers	Strategies to encourage CDC practices

b) Recognition of staff members' skills & achievements

Barriers	Strategies to overcome challenges	Enablers	Strategies to encourage CDC practices

c) Work place fairness and innovation

Barriers	Strategies to overcome challenges	Enablers	Strategies to encourage CDC practices

d) Trust (in the work place)

Barriers	Strategies to overcome challenges	Enablers	Strategies to encourage CDC practices

e) Support & cohesion amongst team members

Barriers	Strategies to overcome challenges	Enablers	Strategies to encourage CDC practices

f) Workplace pressure

Barriers	Strategies to overcome challenges	Enablers	Strategies to encourage CDC practices

INSTRUCTIONS

The purpose of this worksheet is to provide a guide for brainstorming and recording your ideas about potential factors that may challenge or facilitate successful implementation of CDC at your facility. You will be working on this worksheet throughout the program – you may also like to keep using it after the program ends.

Barriers

a. What problems might arise when you implement the new CDC approach at your facility? Consider these potential challenges in relation to each of the organisational factors that facilitate staff confidence. Write your ideas in the "Barriers" column for each of the 5 factors.

Additional questions, for your reflection (no need to write these in your workbook):

b. When could these issues arise?

c. Are these issues related to:

- the way your facility works (e.g. gaps in the system/ current processes);
- the way the staff members work together (e.g. working relationship with team members; poor communication among your colleagues);
- the current leadership styles and behaviours of senior staff ?
- the working relationship you have with the residents?

What are some potential barriers related to residents' cognitive capacity (e.g. cognitive impairment or dementia), which may affect their participation in CDC?

Enablers

a. What are the positive things that can help you and your facility apply a CDC approach to care? Consider these "enablers" in relation to each of the organisational factors that facilitate staff confidence. Write your ideas in the "Enablers" column for each of the 5 factors.

Additional questions, for your reflection (no need to write these in your workbook):

b. When might these opportunities for improvement arise?

c. Are these positive things related to:

- the way your facility works (e.g. procedures and processes);
- the way the staff members work together (e.g. working relationship with team members; good communication among your colleagues);
- the current leadership styles and behaviours of senior staff?
- the working relationship you have with the residents?

What factors could promote greater resident participation and involvement in the CDC process (e.g. making their own care decisions, developing a strong collaborative relationship with the staff)?

APPENDIX C

—

RESIDENT SURVEY

CONSUMER DIRECTED CARE IN RESIDENTIAL AGED CARE:

Implementation of the Resident at the Centre of Care

Survey Pack - Residents

Participant Name: _____

Facility: _____

Please note that this survey pack is to be administered by a member of the research team from the Institute for Health and Ageing.

Instructions to residents:

The following surveys will ask a range of questions about your views about your quality of life, your perceptions of quality of care, and your experience of the Consumer Directed Approach to care. There are no right or wrong answers, just your personal opinion.

I will read each question to you, and you will be asked to provide an answer based on the scale provided [show example of scales]. If needed, we can take a break part-way through.

Administered by: _____

Demographic Information

Please provide some background information about yourself:

1. Age: _____ years

2. Gender

- ☐ Male
- ☐ Female

3. Highest level of education

- ☐ Did not complete final year of secondary school
- ☐ Final year of secondary school
- ☐ Certificate or Diploma
- ☐ Undergraduate degree
- ☐ Postgraduate degree

4. Country of birth:

_____

5. Is English your second language?

- ☐ Yes
- ☐ No

6. Communication difficulties:

- ☐ Nil
- ☐ Hearing impairment
- ☐ Vision impairment
- ☐ Speech impairment
- ☐ Other communication difficulty:

_____

7. Cognitive impairment (tick all that apply)

- ☐ No cognitive impairment – N/A
- ☐ Mild Cognitive Impairment (MCI)
- ☐ Alzheimer's disease
- ☐ Vascular dementia
- ☐ Lewy body disease
- ☐ Frontotemporal dementia
- ☐ Other: (please specify)

_____

8. PAS - cognitive decline

Score: _____ Date of Ax: _____

9. Approximately, how long have you lived in your current Residential Aged Care Facility?

_____ years _____ months

10. Have you lived in another Residential Aged Care Facility?

- ☐ Yes
- ☐ No

11. Approximately how long have you lived in a Residential Aged Care Facility, in total?

_____ years _____ months

12. Alternative decision maker?

- ☐ Yes (provide details) Name, contact details & relationship to resident:

_____

_____

_____

- ☐ No

13. In the past week, did you require regular assistance from family members or friends?

- [ ] Yes
- [ ] No

If yes, please tick what tasks they assisted you with and record how many hours of assistance they provided *(approximate is ok):*

- [ ] Personal care tasks *(e.g. eating, grooming, bathing, dressing)* _____ hours
- [ ] Community tasks *(e.g. transport, shopping, making appointments)* _____ hours
- [ ] Domestic tasks *(e.g. preparing meals for you)* _____ hours
- [ ] Other: _____ *(please describe)* _____ hours

14. Psychotropic medication?

_____

_____ Regular / PRN

_____

_____ Regular / PRN

_____ Regular / PRN

_____

_____ Regular / PRN

Consumer Directed Care

1. Have you ever heard the term "Consumer Directed Care"?

- [ ] Yes
- [ ] No

Please indicate how much you agree or disagree with each statement, using the scale provided.

	Strongly disagree	Disagree	Uncertain	Agree	Strongly agree
I am confident that I could accurately define Consumer Directed Care.	1	2	3	4	5
I do not like the way that my carers have worked with me to develop or revise my care plan.	1	2	3	4	5
I am happy with how much choice I am given about my care.	1	2	3	4	5
I do enough for myself.	1	2	3	4	5
I would like to do more for myself.	1	2	3	4	5
I am able to make my own decisions about what is in my care plan.	1	2	3	4	5

Quality of Life: AD

Interviewer to administer according to standard instructions. Circle responses.

1. Physical health	Poor	Fair	Good	Excellent
2. Energy	Poor	Fair	Good	Excellent
3. Mood	Poor	Fair	Good	Excellent
4. Living situation	Poor	Fair	Good	Excellent
5. Memory	Poor	Fair	Good	Excellent
6. Family	Poor	Fair	Good	Excellent
7. People who work here	Poor	Fair	Good	Excellent
8. Friends	Poor	Fair	Good	Excellent
9. Self overall	Poor	Fair	Good	Excellent
10. Ability to keep busy	Poor	Fair	Good	Excellent
11. Ability to do things for fun	Poor	Fair	Good	Excellent
12. Ability to take care of myself	Poor	Fair	Good	Excellent
13. Ability to live with others	Poor	Fair	Good	Excellent
14. Ability to make choices in my life	Poor	Fair	Good	Excellent
15. Life overall	Poor	Fair	Good	Excellent

Balanced Measure of Psychological Needs

Please read each of the following items carefully, thinking about how it relates to your life over the past week. Please indicate how much you agree with each statement, using the scale provided.

	Strongly disagree				Strongly agree
I felt a sense of contact with people who care about me, and whom I care about.	1	2	3	4	5
I successfully completed difficult tasks and projects.	1	2	3	4	5
I was free to do things my own way.	1	2	3	4	5
I was lonely.	1	2	3	4	5
I experienced some kind of failure, or was unable to do well at something.	1	2	3	4	5
I had a lot of pressures I could do without.	1	2	3	4	5
I felt close and connected with other people who are important to me.	1	2	3	4	5
I took on and mastered hard challenges.	1	2	3	4	5
My choices expressed my “true self”.	1	2	3	4	5
I felt unappreciated by one or more important people.	1	2	3	4	5
I did something stupid that made me feel incompetent.	1	2	3	4	5
There were people telling me what I had to do.	1	2	3	4	5
I felt a strong sense of intimacy with the people I spent time with.	1	2	3	4	5
I did well, even at the hard things.	1	2	3	4	5
I was doing what really interests me.	1	2	3	4	5
I had disagreements or conflicts with people I usually get along with.	1	2	3	4	5
I struggled doing something I should be good at.	1	2	3	4	5
I had to do things against my will.	1	2	3	4	5

Working Alliance

The following section includes questions about your relationship with the care staff at your Residential Aged Care Facility. Please read each question carefully, and indicate how often each statement occurs. There are no right or wrong answers and please know that your responses will remain confidential.

	Strongly disagree				Strongly agree
My carers speak with me about my thoughts and wishes about the care that I receive.	0	1	2	3	4
My carers and I are open with one another about what we expect of each other.	0	1	2	3	4
My carers and I have a trusting relationship.	0	1	2	3	4
My carers and I have an honest relationship.	0	1	2	3	4
My carers and I agree on my goals and care preferences.	0	1	2	3	4
My carers are stern with me when I speak about things that are important to me and my situation	0	1	2	3	4
My carer and I agrees on the kinds of things that could be changed that would make things better for me.	0	1	2	3	4
My carers are impatient with me.	0	1	2	3	4
My carers and I agree about what is important for me to work on.	0	1	2	3	4
I believe my carers understand how important choice is to me.	0	1	2	3	4
I believe my carers understand how I would like my daily activities completed.	0	1	2	3	4

Care Satisfaction Survey

Wake Up & Bed Time

I am happy with the time of day that staff wake me up:	Yes	No
I am happy with the time of day that staff help me prepare for bed:	Yes	No
Is there anything you would like to change about when you get up or go to bed?	Yes	No
Comments:	☐ Assistance not required	

Dressing

I am happy with the way staff help me dress:	Yes	No
Is there anything you would like to change about how staff help you dress?	Yes	No
Comments:	☐ Assistance not required	

Bathing

I am happy with the way staff help me bathe:	Yes	No
Is there anything you would like to change about how staff help you bathe?	Yes	No
Comments:	☐ Assistance not required	

Grooming

I am happy with the way staff help me with daily grooming:	Yes	No
Is there anything you would like to change about how staff help with your daily grooming?	Yes	No
Comments:	☐ Assistance not required	

Pampering & Beauty

I am happy with the way staff help me with my pampering and beauty needs:	Yes	No
Is there anything you would like to change about how staff help you with your pampering and beauty needs?	Yes	No
Comments: ☐ Assistance not required		

Skin Care

I am happy with the way staff help me with my skin care needs:	Yes	No
Is there anything you would like to change about how staff help with your skin care needs?	Yes	No
Comments: ☐ Assistance not required		

Toileting

I am happy with the way staff help me with my toileting needs:	Yes	No
Is there anything you would like to change about how staff help with your toileting needs?	Yes	No
Comments: ☐ Assistance not required		

Pain Management

I am happy with the way staff help me with my pain management needs:	Yes	No
Is there anything you would like to change about how staff help you manage your pain?	Yes	No
Comments: ☐ Assistance not required		

Transfers, Mobility & Dexterity

I am happy with the way staff help me to move around:	Yes	No
Is there anything you would like to change about how staff help you to move around?	Yes	No
I am happy with the way staff help me to get in or out of bed or a chair:	Yes	No
Is there anything you would like to change about how staff help you to get in or out of bed or a chair?	Yes	No
Comments: ☐ Assistance not required		

Medical & Allied Health Services

I am happy with the services I currently receive:	Yes	No
I know enough about the different services I could receive (if I wanted to):	Yes	No
Is there anything you would like to change about the services that you receive?	Yes	No
Comments: ☐ Assistance not required		

Social & lifestyle activities

I am happy with the social life here:	Yes	No
I am happy with the activities here:	Yes	No
I would like to change the activities we do here:	Yes	No
Is there anything you would like to change about your activities here?	Yes	No
Is there anything you would like to change about your social life here?		
Comments: ☐ Assistance not required		

Eating & Drinking

I am happy with the way staff help me with meals:	Yes	No
Is there anything you would like to change about how staff help with your meals?	Yes	No
Comments: ☐ Assistance not required		

Meal Choices

I am happy with the foods and drinks we have here:	Yes	No
Is there anything you would like to change about the food and drinks we have here?	Yes	No
Comments: ☐ Assistance not required		

Communication or Relationships

I enjoy talking to others:	Yes	No
I have enough people to talk to:	Yes	No
I like to talk to other residents:	Yes	No
I like to talk to staff:	Yes	No
I would like more opportunity to talk to others:	Yes	No
Is there anything you would like to change about who you talk to or the conversations you have?		
Comments: ☐ Assistance not required		

End of survey

APPENDIX D

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STAFF SURVEY

CONSUMER DIRECTED CARE IN RESIDENTIAL AGED CARE:

Implementation of the Resident at the Centre of Care

Survey Pack

Participant Name: _____

Facility: _____

Instructions:

The following surveys will ask a range of questions about your job satisfaction, perceptions of your workplace, working relationship with residents, and leadership style.

All responses are confidential – they will be used solely for the purpose of research relating to the RCC program and will not be disclosed to your workplace.

Demographic Information

Please provide some information about yourself:

1. Age

- ☐ 24 and under
- ☐ 25-34
- ☐ 35-44
- ☐ 45-54
- ☐ 55 and above

2. Gender

- ☐ Male
- ☐ Female

3. Highest level of education

- ☐ Did not complete final year of secondary school
- ☐ Final year of secondary school
- ☐ Certificate or Diploma
- ☐ Undergraduate degree
- ☐ Postgraduate degree

4. Country of birth:

_____

5. Current role/job title:

_____

6. How many hours per week do you work at the facility listed above?

_____ hours p/week

7. Approximately, how long have you worked in your current role at the facility listed above?

_____ years _____ months

8. Approximately, how long have you worked in your current role overall (include all employers/facilities)?

_____ years _____ months

9. Approximately, how long have you worked in the Aged Care industry (in any role/position)?

_____ years _____ months

Consumer Directed Care

Please indicate how much you agree or disagree with each statement, using the scale provided.

	Strongly disagree	Disagree	Uncertain	Agree	Strongly agree
1. I am confident that I could accurately define Consumer Directed Care.	1	2	3	4	5
2. The residents do not like to be involved in developing or revising their care plan.	1	2	3	4	5
3. Residents are happy with how much choice they are given about their care.	1	2	3	4	5
4. I believe residents do enough for themselves.	1	2	3	4	5
5. I believe residents could do more for themselves.	1	2	3	4	5
6. Residents are able to decide what is in their care plan.	1	2	3	4	5

7. Have you ever completed training or education in relation to Consumer Directed Care?

- ☐ Yes
- ☐ No

8. What do you think would be something *positive* about Consumer Directed Care in relation to:

The care of residents:

Your work life:

The functioning of the facility:

9. What do you think would be something negative about Consumer Directed Care in relation to:

The care of residents:

Your work life:

The functioning of the facility:

Leadership style

This questionnaire provides a description of your leadership style. Read each statement and judge how frequently it applies to you. The word "others" may mean your colleagues or staff you supervise.

	Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
1. I provide others with assistance in exchange for their efforts.	0	1	2	3	4
2. I re-examine critical assumptions to question whether they are appropriate.	0	1	2	3	4
3. I fail to interfere until problems become serious.	0	1	2	3	4
4. I focus attention on irregularities, mistakes, exceptions, and deviations from standards.	0	1	2	3	4
5. I avoid getting involved when important issues arise.	0	1	2	3	4
6. I talk about my most important values and beliefs.	0	1	2	3	4
7. I am absent when needed.	0	1	2	3	4
8. I seek differing perspectives when solving problems.	0	1	2	3	4
9. I talk optimistically about the future.	0	1	2	3	4
10. I instil pride in others for being associated with me.	0	1	2	3	4
11. I discuss in specific terms who is responsible for achieving performance targets.	0	1	2	3	4
12. I wait for things to go wrong before taking action.	0	1	2	3	4
13. I talk enthusiastically about what needs to be accomplished.	0	1	2	3	4
14. I specify the importance of having a strong sense of purpose.	0	1	2	3	4
15. I spend time teaching and coaching.	0	1	2	3	4
16. I make clear what one can expect to receive when performance goals are achieved.	0	1	2	3	4
17. I show that I am a firm believer in "If it ain't broke, don't fix it".	0	1	2	3	4
18. I go beyond self-interest for the good of the group.	0	1	2	3	4
19. I treat others as individuals rather than just as a member of the group.	0	1	2	3	4
20. I demonstrate that problems must become chronic before I take action.	0	1	2	3	4
21. I act in ways that build others' respect for me.	0	1	2	3	4

	Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
22. I concentrate my full attention on dealing with mistakes, complaints and failures.	0	1	2	3	4
23. I consider the moral and ethical consequences of decisions.	0	1	2	3	4
24. I keep track of all mistakes.	0	1	2	3	4
25. I display a sense of power and confidence.	0	1	2	3	4
26. I articulate a compelling vision of the future.	0	1	2	3	4
27. I direct my attention toward failures to meet standards.	0	1	2	3	4
28. I avoid making decisions.	0	1	2	3	4
29. I consider each individual as having different needs, abilities, and aspiration from others.	0	1	2	3	4
30. I get others to look at problems from many different angles.	0	1	2	3	4
31. I help others to develop their strengths.	0	1	2	3	4
32. I suggest new ways of looking at how to complete tasks.	0	1	2	3	4
33. I delay responding to urgent questions.	0	1	2	3	4
34. I emphasise the importance of having a collective sense of mission.	0	1	2	3	4
35. I express satisfaction when others meet expectations.	0	1	2	3	4
36. I express confidence that goals will be achieved.	0	1	2	3	4
37. I am effective in meeting others' job related needs.	0	1	2	3	4
38. I use methods of leadership that are satisfying.	0	1	2	3	4
39. I get others to do more than they are expected to do.	0	1	2	3	4
40. I am effective in representing my group to a higher authority.	0	1	2	3	4
41. I work with others in a satisfactory way.	0	1	2	3	4
42. I heighten others' desire to succeed.	0	1	2	3	4
43. I am effective in meeting organisational requirements.	0	1	2	3	4
44. I increase others' willingness to try harder.	0	1	2	3	4
45. I lead a group that is effective.	0	1	2	3	4

Job satisfaction

In this section, please circle the appropriate number to indicate how satisfied or dissatisfied you are with various aspects of your job.

	Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
1. Job security (stable work)	1	2	3	4	5
2. Physical conditions (light, ventilation, etc.)	1	2	3	4	5
3. Fringe benefits (company discounts, superannuation, etc.)	1	2	3	4	5
4. Pay you receive for you job	1	2	3	4	5
5. The recognition you get when you do a good job	1	2	3	4	5
6. The freedom you have to do the best you can at your job	1	2	3	4	5
7. Your advancement to better positions since you started working for this organization	1	2	3	4	5
8. The work you do	1	2	3	4	5

The following statements are related to your intention to stop working for this organisation. Your responses to these items are for the purpose of the study only and will not be disclosed to your employer.

1. How often do you think about leaving your job?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often Always

2. How likely are you to look for a new job within the next year?

- ☐ Extremely unlikely
- ☐ Unlikely
- ☐ Neutral
- ☐ Likely
- ☐ Extremely likely

Organisational environment

Please indicate how much you agree or disagree with the following statements, using the scale provided.

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
1. I make the most of the decisions that affect the way my job is performed	1	2	3	4	5
2. I determine my own work procedures	1	2	3	4	5
3. I schedule my own work activities	1	2	3	4	5
4. I set the performance standards for my job	1	2	3	4	5
5. I organise my work as I see best.	1	2	3	4	5
6. People pitch in to help each other out	1	2	3	4	5
7. People tend to get along with each other	1	2	3	4	5
8. People take a personal interest in one another	1	2	3	4	5
9. There is a lot of “team spirit” among people at my work	1	2	3	4	5
10. I feel like I have a lot in common with the people I know at my work	1	2	3	4	5
11. I can count on my work colleagues to keep the things I tell them confidential	1	2	3	4	5
12. My work colleagues have a lot of personal integrity	1	2	3	4	5
13. My work colleagues are the kind of people I can level with	1	2	3	4	5
14. My work colleagues are not likely to give me bad advice	1	2	3	4	5
15. My work colleagues keep their commitments	1	2	3	4	5
16. I have too much work and too little time to do it in	1	2	3	4	5
17. My work is a relaxed place to work	1	2	3	4	5
18. At home, I sometimes dread hearing the telephone ring because it might be someone calling about a job-related problem	1	2	3	4	5
19. I feel like I never have a day off	1	2	3	4	5
20. Too many employees at my level at work get “burned out” by the demands of their jobs	1	2	3	4	5
21. I can count on my work colleagues to help me when I need it	1	2	3	4	5
22. My work colleagues are interested in me getting ahead in the company	1	2	3	4	5
23. My work colleagues are behind me 100%.	1	2	3	4	5
24. My work colleagues are easy to talk to about job-related problems	1	2	3	4	5

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
25. My work colleagues back me up and lets me learn from my mistakes	1	2	3	4	5
26. I can count on a pat on the back when I perform well	1	2	3	4	5
27. The only time I hear about my performance is when I screw up	1	2	3	4	5
28. My work colleagues know what my strengths are and let me know it	1	2	3	4	5
29. My work colleagues are quick to recognise good performance	1	2	3	4	5
30. My work colleagues use me as an example of what to do	1	2	3	4	5
31. I can count on a fair go from my work colleagues	1	2	3	4	5
32. The objectives my boss sets for my job are reasonable	1	2	3	4	5
33. My boss is not likely to give me a bad deal	1	2	3	4	5
34. My boss does not play favourites	1	2	3	4	5
35. If my boss terminates someone, the person probably deserved it	1	2	3	4	5
36. My boss encourages me to develop my ideas	1	2	3	4	5
37. My boss likes me to try new ways of doing my job	1	2	3	4	5
38. My boss encourages me to improve on his/her methods	1	2	3	4	5
39. My boss encourages me to find new ways around old problems	1	2	3	4	5
40. My boss “talks up” new ways of doing things	1	2	3	4	5

Relationships

For the following items, please circle how often each statement applies to you. Please note that "residents" refers to the people who live in the facility.

	Never	Rarely	Some-times	Often	Always
1. I am aware of residents' personal goals and thoughts about the care they receive.	0	1	2	3	4
2. The residents and I are open with one another about what we expect of each other.	0	1	2	3	4
3. The residents and I have a trusting relationship.	0	1	2	3	4
4. The residents and I have an honest relationship.	0	1	2	3	4
5. The residents and I agree on goals and care preferences.	0	1	2	3	4
6. I feel frustrated when residents talk about changing how their care is provided.	0	1	2	3	4
7. Residents and I address care tasks and activities that can be changed to make things better for them.	0	1	2	3	4
8. I am impatient with residents.	0	1	2	3	4
9. The residents and I agree about what is important for me to work on.	0	1	2	3	4
10. I am aware how important choice is to residents.	0	1	2	3	4
11. I understand how residents would like their daily activities completed.	0	1	2	3	4

For the following items, please indicate how much you agree or disagree with each statement using the rating scale provided.

	Totally disagree					Totally agree
1. I prefer to depend on myself rather than other people.	1	2	3	4	5	6
2. Achieving things is more important than building relationships.	1	2	3	4	5	6
3. Doing your best is more important that getting on with others.	1	2	3	4	5	6
4. It's important to me that others like me.	1	2	3	4	5	6
5. I find it hard to make a decision unless I know what other people think.	1	2	3	4	5	6
6. I find it hard to trust other people.	1	2	3	4	5	6
7. I find it relatively easy to get close to other people.	1	2	3	4	5	6
8. I worry that others won't care about me as much as I care about them.	1	2	3	4	5	6

	Totally disagree					Totally agree
9. I worry a lot about my relationships.	1	2	3	4	5	6
10. I feel confident about relating to others.	1	2	3	4	5	6
11. If something is bothering me, others are generally aware and concerned.	1	2	3	4	5	6
12. I am confident that other people will like and respect me.	1	2	3	4	5	6

Organisational Change

The following items relate to your current perceptions of your organisation in relation to the introduction of a Consumer Directed Approach to care. Please read each item and circle the number that best indicates how much you disagree or agree with each statement.

A: Organisational Readiness – Appropriateness

At this point in time.....	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. I think that the organisation will benefit from this change	1	2	3	4	5
2. It doesn't make much sense for us to initiate this change	1	2	3	4	5
3. There are legitimate reasons for us to make this change	1	2	3	4	5
4. This change will improve our organisation's overall efficiency	1	2	3	4	5
5. There are a number of rational reasons for this change to be made	1	2	3	4	5
6. In the long run, I feel it will be worthwhile for me if the organisation adopts this change	1	2	3	4	5
7. This change makes my job easier	1	2	3	4	5
8. When this change is implemented, I don't believe there is anything for me to gain	1	2	3	4	5
9. The time we are spending on this change should be spent on something else	1	2	3	4	5
10. This change matches the priorities of our organisation	1	2	3	4	5

B: Organisational Readiness – Personally Beneficial

At this point in time.....	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. I am worried I will lose some of my status in the organisation when this change is implemented	1	2	3	4	5
2. This change will disrupt many of the personal relationships I have developed	1	2	3	4	5
3. My future in this job will be limited because of this change	1	2	3	4	5

C: Organisational Readiness – Management Support

At this point in time.....	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. Our senior leaders have encouraged all of us to embrace this change	1	2	3	4	5
2. Our organisation's top decision makers have put all their support behind this change effort	1	2	3	4	5
3. Every senior manager has stressed the importance of this change	1	2	3	4	5
4. This organisation's most senior leader is committed to this change	1	2	3	4	5
5. I think we are spending a lot of time on this change when the senior managers don't even want it implemented	1	2	3	4	5
6. Management has sent a clear signal this organisation is going to change	1	2	3	4	5

D: Organisational Readiness – Change Efficacy

At this point in time.....	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
I do not anticipate any problems adjusting to the work I will have when this change is adopted	1	2	3	4	5
There are some tasks that will be required when we change that I don't think I can do well	1	2	3	4	5
When we implement this change, I feel I can handle it with ease	1	2	3	4	5
I have the skills that are needed to make this change work	1	2	3	4	5
When I set my mind to it, I can learn everything that will be required when this change is adopted	1	2	3	4	5
My past experiences make me confident that I will be able to perform successfully after this change is made	1	2	3	4	5

End of survey

Thank you for completing this survey – your support is greatly appreciated

APPENDIX E

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RESOURCE USE QUESTIONNAIRE (ECONOMIC EVALUATION)

RESIDENTIAL AGED CARE FACILITY: RESOURCE USE QUESTIONNAIRE (BASELINE)

Thank you for taking the time to complete this questionnaire. We are interested in understanding the current operational and running costs of this facility i.e. in the past month.

Where applicable, you can report resources for the specific unit or section of the facility participating in the Resident at the Centre of Care Program. It may not always be possible to do this, for example where resources are shared across the facility, so the final question asks you to indicate if resources reported are unit-specific or facility-wide for each question.

Name of aged care facility: _____

Person completing the questionnaire: _____

Contact email address: _____

Question 1.

On a typical weekday, how many direct care staff were rostered to work morning, afternoon and night shifts? Please indicate the total Full Time Equivalent (FTE) employed by profession, the level/classification/grade and if the profession is employed directly by the facility.

			Morning	Afternoon	Night
Profession	**Description eg. Level**	**Employed by the facility Yes/No**	**FTE**	**FTE**	**FTE**
Nurse Practitioner					
Registered Nurse					
Enrolled Nurse					
Personal Care Attendant					
Physiotherapist					
Speech Therapist					
Occupational Therapist					
Dietitian					
Podiatrist					
Dentist					
Optometrist					
Audiologist					
General Practitioner					
Geriatrician					
Other (please specify)					

Question 2.

On a typical Saturday or Sunday, how many direct care staff were rostered to work morning, afternoon and night shifts? Please indicate the total Full Time Equivalent (FTE) employed by profession, the level/classification/grade and if the profession is employed directly by the facility.

			Morning	Afternoon	Night
Profession	**Description eg. Level**	**Employed by the facility Yes/No**	**FTE**	**FTE**	**FTE**
Nurse Practitioner					
Registered Nurse					
Enrolled Nurse					
Personal Care Attendant					
Physiotherapist					
Speech Therapist					
Occupational Therapist					
Dietitian					
Podiatrist					
Dentist					
Optometrist					
Audiologist					
General Practitioner					
Geriatrician					
Other (please specify)					

Question 3.

On a typical weekday, how many staff in management and/or administration positions were employed in this facility? Please indicate the total Full Time Equivalent (FTE) employed by profession, the level/classification/grade and if the profession is employed directly by the facility.

Profession	Description	Employed by the facility Yes/No	FTE
Facility Manager			
Finance Manager			
Regional Manager			
Resident Liaison Officer			
Clinical Care Coordinator			
Care Support Coordinator			
Rostering Coordinator			
Education Officer			
Quality Officer			
Work Health and Safety Officer			
Pastoral Care Worker			
ACFI Officer			
In-Reach Officer			
Administrative Officer			
Other (please specify)			

Question 4.

On a typical weekday, how many staff were rostered to provide social activities during morning, afternoon and night shift (if applicable)? Please indicate the total Full Time Equivalent (FTE) employed by profession, the level/classification/grade and if the profession is employed directly by the facility.

			AM	PM	Night
Profession	**Description eg. Level**	**Employed by the facility Yes/No**	**FTE**	**FTE**	**FTE**
Lifestyle Coordinator					
Lifestyle Assistant					
Other (please specify)					

Question 5.

In the past month, how many volunteers contributed their time to support residents? Please indicate the total number of volunteers and hours of time contributed.

Profession	Number of volunteers	Total monthly hours
Volunteer		

Question 6.

In the past month, were staff employed by this facility to provide 'hotel services' to residents or were these services outsourced to an external provider? Please indicate the total cost of these services in the past month (excluding staffing costs).

	Provided onsite (Yes/No)	Outsourced (Yes/No)	Total monthly cost ($)
Hotel service			
Food services			
Cleaning			
Laundry			
Maintenance			
Transportation			
Other (please detail):			

For services provided onsite and on a typical day, how many staff were rostered to work morning, afternoon and night shift? Please indicate the total Full Time Equivalent (FTE) employed by profession and the level/ classification/grade.

		Morning	Afternoon	Night
Profession	Description eg. Level	FTE	FTE	FTE
Food Services Assistant				
Cleaning Services Assistant				
Laundry Services Assistant				
Maintenance Officer				
Transportation Assistant				
Other (please specify)				

Question 7.

In the past week, how many days of unplanned leave were taken by direct care staff, hotel service staff and lifestyle staff (where applicable) employed at this facility? Unplanned leave refers to sick leave, non-attendance or other unexpected days off work. Please indicate if a replacement worker was typically sought and if a higher hourly rate applied *(e.g. penalty rates, higher level/grade replacement worker).

MONDAY	AM	PM	Night	Replacement (Yes/No)	Higher hourly rate (Yes/No)*
Nurse Practitioner					
Registered Nurse					
Enrolled Nurse					
Personal Care Attendant					
Physiotherapist					
Speech Therapist					
Occupational Therapist					
Dietitian					
Podiatrist					
Dentist					
Optometrist					
Audiologist					
General Practitioner					
Geriatrician					
Food Services Assistant					
Cleaning Services Assistant					
Laundry Services Assistant					
Maintenance Officer					
Transportation Assistant					
Lifestyle Coordinator					
Lifestyle Assistant					
Other (please specify)					

TUESDAY	AM	PM	Night	Replacement (Yes/No)	Higher hourly rate (Yes/No)*
Nurse Practitioner					
Registered Nurse					
Enrolled Nurse					
Personal Care Attendant					
Physiotherapist					
Speech Therapist					
Occupational Therapist					
Dietitian					
Podiatrist					
Dentist					
Optometrist					
Audiologist					
General Practitioner					
Geriatrician					
Food Services Assistant					
Cleaning Services Assistant					
Laundry Services Assistant					
Maintenance Officer					
Transportation Assistant					
Lifestyle Coordinator					
Lifestyle Assistant					
Other (please specify)					

AM: Morning Shift; PM: Afternoon shift.

WEDNESDAY	AM	PM	Night	Replacement (Yes/No)	Higher hourly rate (Yes/No)*
Nurse Practitioner					
Registered Nurse					
Enrolled Nurse					
Personal Care Attendant					
Physiotherapist					
Speech Therapist					
Occupational Therapist					
Dietitian					
Podiatrist					
Dentist					
Optometrist					
Audiologist					
General Practitioner					
Geriatrician					
Food Services Assistant					
Cleaning Services Assistant					
Laundry Services Assistant					
Maintenance Officer					
Transportation Assistant					
Lifestyle Coordinator					
Lifestyle Assistant					
Other (please specify)					

THURSDAY	AM	PM	Night	Replacement (Yes/No)	Higher hourly rate (Yes/No)*
Nurse Practitioner					
Registered Nurse					
Enrolled Nurse					
Personal Care Attendant					
Physiotherapist					
Speech Therapist					
Occupational Therapist					
Dietitian					
Podiatrist					
Dentist					
Optometrist					
Audiologist					
General Practitioner					
Geriatrician					
Food Services Assistant					
Cleaning Services Assistant					
Laundry Services Assistant					
Maintenance Officer					
Transportation Assistant					
Lifestyle Coordinator					
Lifestyle Assistant					
Other (please specify)					

AM: Morning Shift; PM: Afternoon shift.

FRIDAY	AM	PM	Night	Replacement (Yes/No)	Higher hourly rate (Yes/No)*
Nurse Practitioner					
Registered Nurse					
Enrolled Nurse					
Personal Care Attendant					
Physiotherapist					
Speech Therapist					
Occupational Therapist					
Dietitian					
Podiatrist					
Dentist					
Optometrist					
Audiologist					
General Practitioner					
Geriatrician					
Food Services Assistant					
Cleaning Services Assistant					
Laundry Services Assistant					
Maintenance Officer					
Transportation Assistant					
Lifestyle Coordinator					
Lifestyle Assistant					
Other (please specify)					

SATURDAY	AM	PM	Night	Replacement (Yes/No)	Higher hourly rate (Yes/No)*
Nurse Practitioner					
Registered Nurse					
Enrolled Nurse					
Personal Care Attendant					
Physiotherapist					
Speech Therapist					
Occupational Therapist					
Dietitian					
Podiatrist					
Dentist					
Optometrist					
Audiologist					
General Practitioner					
Geriatrician					
Food Services Assistant					
Cleaning Services Assistant					
Laundry Services Assistant					
Maintenance Officer					
Transportation Assistant					
Lifestyle Coordinator					
Lifestyle Assistant					
Other (please specify)					

AM: Morning Shift; PM: Afternoon shift.

SUNDAY	AM	PM	Night	Replacement (Yes/No)	Higher hourly rate (Yes/No)*
Nurse Practitioner					
Registered Nurse					
Enrolled Nurse					
Personal Care Attendant					
Physiotherapist					
Speech Therapist					
Occupational Therapist					
Dietitian					
Podiatrist					
Dentist					
Optometrist					
Audiologist					
General Practitioner					
Geriatrician					
Food Services Assistant					
Cleaning Services Assistant					
Laundry Services Assistant					
Maintenance Officer					
Transportation Assistant					
Lifestyle Coordinator					
Lifestyle Assistant					
Other (please specify)					

AM: Morning Shift; PM: Afternoon shift.

Question 8

Please indicate if your answers to this Resource Use Questionnaire are unit-specific (i.e. for the unit participating in the Resident at the Centre of Care Program) or facility-wide:

Question number	Unit or facility
1 Direct Care Staff (weekday)	
2 Direct Care Staff (weekend)	
3 Management and Administration Staff	
4 Social Support Staff	
5 Volunteers	
6 Hotel Service Staff and Monthly Cost	
7 Unplanned Leave	

How many residents live in the Unit you have reported resource use for (where applicable)?

_____ residents

How many residents live in the Facility you have reported resource use for (where applicable)?

_____ residents

Question 9.

Please provide any additional information or feedback (if required).

This is the end of the questionnaire. Thank you for your time.

APPENDIX F

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PROGRAM FEEDBACK FORM

RESIDENT AT THE CENTRE OF CARE (RCC)

PROGRAM FEEDBACK FORM – SENIOR STAFF

The research team have appreciated your input and feedback so far. We would now appreciate some more detail about your experience of completing the Resident at the Centre of Care program. Your insights and reflections will contribute to future versions of this program.

RCC Program overall

For each statement, please circle the number that best matches your response.

		Strongly Agree	Agree	Uncertain/ Unsure	Disagree	Strongly Disagree
1.	I found the content easy to understand.	1	2	3	4	5
2.	The material covered was relevant to my role.	1	2	3	4	5
3.	The training was well organised.	1	2	3	4	5
4.	The RCC program has helped my workplace determine how to transition to a Consumer Directed Care model of care.	1	2	3	4	5

Topic 1: What is Consumer Directed Care

Please respond to the following statements in relation to the topic “What is Consumer Directed Care”. For each statement, please circle the number that best matches your response.

		Strongly Agree	Agree	Uncertain/ Unsure	Disagree	Strongly Disagree
1.	I found the content easy to understand.	1	2	3	4	5
2.	This topic was relevant to my role.	1	2	3	4	5
3.	My work practice will change because of this topic.	1	2	3	4	5
4.	This topic helped further my understanding of CDC.	1	2	3	4	5

Topic 2: Carer-Resident Collaborative Relationship

Please respond to the following statements in relation to the topic "Carer-Resident Collaborative Relationship". For each statement, please circle the number that best matches your response.

		Strongly Agree	Agree	Uncertain/ Unsure	Disagree	Strongly Disagree
1.	I found this topic easy to understand.	1	2	3	4	5
2.	This topic was relevant to my role.	1	2	3	4	5
3.	My work practice will change because of this topic.	1	2	3	4	5
4.	This topic helped further my understanding of CDC.	1	2	3	4	5

Topic 3: Key Organisational Factors (e.g. staff autonomy & recognition)

Please respond to the following statements in relation to the topic "Key Organisational Factors". For each statement, please circle the number that best matches your response.

		Strongly Agree	Agree	Uncertain/ Unsure	Disagree	Strongly Disagree
1.	I found this topic easy to understand.	1	2	3	4	5
2.	This topic was relevant to my role.	1	2	3	4	5
3.	My work practice will change because of this topic.	1	2	3	4	5
4.	This topic helped further my understanding of CDC.	1	2	3	4	5

Topic 4: Transformational Leadership

Please respond to the following statements in relation to the topic of "Transformational Leadership". For each statement, please circle the number that best matches your response.

		Strongly Agree	Agree	Uncertain/ Unsure	Disagree	Strongly Disagree
1.	I found this topic easy to understand.	1	2	3	4	5
2.	This topic was relevant to my role.	1	2	3	4	5
3.	My work practice will change because of this topic.	1	2	3	4	5
4.	This topic helped further my understanding of CDC.	1	2	3	4	5

Topic 5: The Skilled Communicator

Please respond to the following statements in relation to the topic "The Skilled Communicator". For each statement, please circle the number that best matches your response.

		Strongly Agree	Agree	Uncertain/ Unsure	Disagree	Strongly Disagree
1.	I found this topic easy to understand.	1	2	3	4	5
2.	This topic was relevant to my role.	1	2	3	4	5
3.	My work practice will change because of this topic.	1	2	3	4	5
4.	This topic helped further my understanding of CDC.	1	2	3	4	5

Activities

For the following statements, please think about the activities completed as part of the RCC program. This includes exploring barriers and enablers, administering the Resident Care form, creating a CDC implementation plan, and so on. For each statement, please circle the number that best matches your response.

		Strongly Agree	Agree	Uncertain/ Unsure	Disagree	Strongly Disagree
1.	The activities helped further my understanding of CDC.	1	2	3	4	5
2.	The activities were relevant to the content and aims of the RCC program.	1	2	3	4	5
3.	The activities helped determine how to implement CDC in my workplace.	1	2	3	4	5
4.	I enjoyed working with my colleagues as part of the activities.	1	2	3	4	5

1. What did you enjoy most about the RCC program?

2. What did you find most challenging about the RCC program?

3. What did you find most useful or informative about the program and why?

4. Do you have any further questions that you need answered?

5. Can you think of any topics or activities that need to be covered in future versions of the program? Are there any that could be condense or removed?

6. Are there any other comments you would like to make?

Thank you for your feedback, it is greatly appreciated

AUSTRALIAN CATHOLIC UNIVERSITY
INSTITUTE FOR HEALTH AND AGEING

Level 6, 215 Spring Street, Melbourne Vic 3000
Email: IHA@acu.edu.au
Phone: +61 3 9230 8170
www.iha.acu.edu.au