Who do you say I am?

Language, Culture and their Intersection with Quality in Residential Aged Care

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Thesis submitted in fulfilment of the requirements for the degree of

Doctor of Philosophy

under the supervision of
Associate Professor Deborah Debono,
Professor Phillippa Carnemolla,
Dr. Suyin Hor, and
The Late Professor Joanne F. Travaglia.

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CERTIFICATE OF ORIGINAL AUTHORSHIP

I, Linda Justin, declare that this thesis is submitted in fulfilment of the requirements for the award of Doctor of Philosophy, in the School of Public Health / Faculty of Health, at the University of Technology Sydney.

This thesis is wholly my own work unless otherwise referenced or acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis. This document has not been submitted for qualifications at any other academic institution.

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ABSTRACT

This thesis investigates the shift in language from “person-centred care” to “consumer-directed care” in Australian aged care policy, and its implications for the implementation of person-centred care models aimed at enhancing quality of care and quality of life for older people. Motivated by first-hand experiences in the aged care sector, this research seeks to understand the ways in which language–particularly how the older person is referred to, such as “patient”, “care recipient”, “consumer”, “person”, and “participant”, in policy documents and research–influences residential aged care providers’ culture and practices of person-centred care. An explanatory mixed-methods approach was employed. The quantitative phase involved content and sentiment analysis using Leximancer across five major national reviews and inquiries into aged care (2011–2021), revealing a marked shift in policy discourse towards “consumer-directed care”. These findings informed the qualitative phase, which included 46 semi-structured interviews with CEOs, cultural change facilitators, academics and researchers, as well as nine site visits to residential aged care facilities. The qualitative component identifies how terminology from policy documents influences practices in residential aged care, particularly the implementation of person-centred care models aimed at improving the quality of care and life for older people. It finds that while terminology matters, the way terms are interpreted is even more significant. The research highlights a critical confusion in the sector, especially in how residents are described, whether as “consumers” or within the framework of “person-centred care”. This conflation is examined through the lens of Pierre Bourdieu’s social practice theory. By exploring the intersection of language and culture–how language shapes organisational culture and influences care delivery–the study reveals how linguistic choices can unintentionally impact the quality of care. Words extend beyond simple letter combinations forming sounds; they encompass symbolic meanings that influence people in various ways. Words have impact based on the underlying message or intent, the individuals articulating them, and the prevailing socio-political context. By unpacking these linguistic subtleties and their practical effects, the study offers fresh insights into current challenges and proposes strategies to promote more respectful and compassionate care environments. By highlighting the unintended consequences language can have on care quality, these findings are especially timely, since at the time of writing Australia is preparing to implement a new Aged Care Act, which would introduce human rights principles and updated terminology.

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Bizarrely, there are similarities between professional tennis and writing a PhD. Both on the surface appear that it’s all about a singular person, either the athlete or the writer. In fact, this couldn’t be further from the truth, as both require the team who are in the box, coaches/academics, family and friends to assist on the journey. In the case of this endeavour, in my box are a number of experienced coaches and academics, supportive family and amazing friends.

These acknowledgements reflect a journey in two chapters, with one constant. My initial journey started with conversations with Professor Joanne Travaglia with her able and constant colleague and friend Associate Professor Deborah Debono. Jo and Deb, you believed in this topic from the first day, when I created a conceptual illustration of a seesaw on a whiteboard on Level 10 to illustrate competing tensions, which on reflection looked like a Jackson Pollack painting! You both listened with intellectual curiosity and had unstinting belief that it was an important aspect to bring to the table. Jo, you listened with keen interest to the latest update two days before your unexpected passing. I miss you and treasure the email exchanges regarding Bourdieu and Lexi conversations, and our shared love of *The Princess Bride* and *Downtown Abbey*! The academic world is the poorer for your passing and I miss your friendship dearly.

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Hazel Baker, who provided copyediting services according to the IPEd guidelines for editing research theses. Any remaining errors are my own. As an academic editor, you were a joy to work with and your professionalism is unsurpassed.

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Lastly, and not least, to my wonderful husband Paul Bennett, a man of integrity, patience and unstinting support. Thank you for listening to the concepts and discussion; you sharpened my thinking and discussion with your questions. You have sacrificed a lot of shared time for this thesis to be realised. Thank you for believing in me and what this thesis could achieve. Love you!

PROLOGUE

Despite an intense curiosity and love of learning, doing this PhD came as a complete surprise to me. For the last 20-plus years, my professional life has been involved in safety and quality, clinical governance, change transformation and strategy. As I talked through large-scale change transformation with Professor Travaglia, she challenged me with "There's a PhD here". You see, in all my professional roles, despite differing titles, there were synergies that aligned with my personal values and desire to see organisations deliver quality care.

As I thought about these common threads and why safety, quality and culture were so intertwined, I wondered why delivery and execution at both an organisational and practice level were so difficult? Indeed, as I commenced this journey professionally, I was reconciling safety and quality failures for the Royal Commission into Aged Care Quality and Safety, which brought lots more questions, especially as I was doing my literature review concurrently.

I vividly remember asking lots of questions (which I assumed everyone had) and feeling like a crazy person as I asked them and I drew a seesaw on a whiteboard with my supervisors. I used the seesaw to talk about the tensions and what it felt like for an organisation to deliver person-centred models of care that understood and honoured the inherent dignity of individuals. Yet, as with all things, we were not operating in isolation, we were operating within a broader ecosystem. They both listened intently and looked at me with complete belief regarding the importance of the topic, my approach and how it would add to the corpus of knowledge.

Person-centred models of care in aged care environments that seemed to be taken so much for granted actually had limited utility or had not been understood. Equally, buzzwords and language had become so interwoven and commonplace, with actually no real sense of what the terms actually meant. This was confirmed by garnering the opinions of a cross-section of friends about the terms in use and what they meant for them. Interestingly, what was readily apparent can be summed up in a quote from *The Princess Bride*: "You keep using that word. I do not think it means what you think it means" became so applicable as I considered and prepared my questions and broad approach for ethics approval.

The approach that underpins this study, to understand health and social care across Australia in the wake of various policy shifts and how they play out in practice, does, I believe, have relevance and currency for other issues that we are facing as a society.

DEDICATION

This PhD is dedicated to my parents Richard and Emily, who have always believed in me and provided me with every opportunity to contribute to a fairer society. Both were people of faith, courage and compassion, committed to their local communities and determined to ensure a helping hand was always there.

Their loss is sorely felt and sadly came too soon.

Richard

16 June 1936-25 May 2022

Emily

27 May 1938-19 August 2022

It is also dedicated to

Paul

my darling husband, friend and soulmate, or "*Anam chara"*.

You have supported and believed in this work from the outset; I am forever grateful.

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PRESENTATIONS ARISING FROM THIS RESEARCH

Table 1 Associated Presentations

Number	Date	Title	Conference Theme	Organisation
1	8/11/2019	What's in a name?	Out On the Edge: Research Innovation and Emerging Knowledge	The Australasian College of Health Service Management
2	11/6/2020	Who do you say I am? Language, culture and the intersection of quality and safety	Leading for quality	ISQUA, Florence
3	2020	Leading Change	Health Systems and Change Subject	Centre for Health Management, UTS
4	6/5/2021	Who do you say I am? Enabling Change, models and their intersection with practice, quality and safety	Rights Matter	International Federation of Ageing Global Conference, Canada
5	6/5/2021	Who do you say I am? Language culture and their intersection with quality and safety in aged care	Rights Matter	International Federation of Ageing Global Conference, Canada

Number	Date	Title	Conference Theme	Organisation
6	9/9/2022	Who do you say I am: Future Proofing the Language of Policy and Practice	Brave New World	International Dementia Conference, Hammond Care, Sydney
7	2022	Leading Health and Social Care- facilitator	Leading Health and Social Care Subject 96327	Centre for Health Management, UTS
8	June 2023	Disrupt ageism: accelerating and mobilizing healthy ageing globally and locally. Workshop	Challenge-Transformation-Change	International Federation of Ageing Global Conference, Bangkok
9	June 2023	Who do you say I am? Terminology and language of policy as they pertain to implicit ageism	Challenge-Transformation-Change	International Federation of Ageing Global Conference, Bangkok
10	July 2023	Who do you say I am?	PhD promotion video presentation at UTS	UTS
11	September 2023	Invited panellist for implementing person-centred care models	Care about Our Future: Global Symposium for	Biennial Global Ageing Conference,

Number	**Date**	**Title**	**Conference Theme**	**Organisation**
			Sustainable Care and Support	Glasgow, in partnership with National Care Forum and Scottish Care
12	September 2024	Invited keynote to launch the *Dementia in the Commonwealth Report*	In the Arena	International Dementia Conference
13	October 2024	Bloomsbury Radio interview regarding personhood and models of care to support inclusive design	Promotion of civil society ahead of CHOGM	Bloomsbury Radio
14	October 2024	Presenter and Panel Anchor for the *Dementia in the Commonwealth Report*	One Resilient Commonwealth	Commonwealth Heads of Government Meeting, Samoa
15	October 2025	Invited guest expert interview regarding this thesis	Foundations of Healthcare Systems Course 09337	University of Technology Sydney

Glossary of Terms

Acronym	Definition
AA	Ageing Australia > Formerly Aged and Community Care Providers Association (ACCPA)
ACAR	Aged Care Approval Rounds
ACAT	Aged Care Assessment Team
ACSA	Aged & Community Services Australia
ACQSC	Aged Care Quality and Safety Commission
ACSQHC	Australian Commission on Safety and Quality in Health Care
ACWIC	Aged Care Workforce Industry Council
ADL	Activities of Daily Living
AHO	Affiliated Health Organisation
AIHW	Australian Institute of Health and Welfare
AIN	Assistant in Nursing
ACFI	Aged Care Funding Instrument
ACSAA	Aged Care Standard and Accreditation Agency
ACSQHC	Australian Commission on Safety and Quality in Health Care
ALRC	Australian Law Reform Commission
AN-ACC	Australian National Aged Care Classification >Replaced ACFI (Aged Care Funding Instrument)
AQF	Australian Qualifications Framework
CALD	Culturally and Linguistically Diverse
Care Recipient	A person who is being provided with care
CCC	Consumer-Centred Care
CDC	Consumer Directed Care
Client	1. a person or organization using the services of a lawyer or other professional person or company. 2. "insurance tailor-made to a client's specific requirements" 3. *synonyms:* customer · buyer · purchaser · shopper · consumer · user · patient · patron · 4. a person being dealt with by social or medical services.
CHSP	Community Home Support Program
Consumer	1. person who purchases goods and services for personal use. 2. "recession-hit consumers are being lured by cheap prices" · [More] 3. *synonyms:* purchaser, buyer customer shopper, user, end user · client · patron · the public · the market the clientele
COTA	COTA (formerly Council on the Ageing)
Customer	1. a person who buys goods or services from a shop or business. 2. *synonyms:* shopper · consumer · buyer · purchaser · patron · client · regular
DAP	Daily Accommodation Payment

Acronym	Definition
DoHAC	Department of Health and Aged Care
DSA	Dementia Support Australia
DVA	Department of Veterans' Affairs
EN	Enrolled Nurse
EOLC	End-of-Life Care
FWC	Fair Work Commission
GAN	Global Ageing Network
HCP	Home Care Package
HSA	Health Services Association of NSW
IDC	International Dementia Conference
IFA	International Federation for Ageing
IHACPA	Independent Health and Aged Care Pricing Authority
ILUs	Independent Living Units
LASA	Leading Age Services Australia
LHD	Local Health District
MAC	My Aged Care
MPS	Multi-Purpose System
NACA	New Aged Care Act
NACAC	National Aged Care Advisory Council
NDIS	National Disability Insurance Scheme
NPS	Net Promotor Score
NRAS	National Registration and Accreditation Scheme
NSQHS	National Safety and Quality Health Service
NSWNMA	NSW Nurses and Midwives' Association
OIGAC	Office of the Inspector-General of Aged Care
OPAN	Older Persons Advocacy Network
OPMH	Older People's Mental Health
PHN	Primary Health Network
QOL	Quality of Life
RAC	Residential Aged Care
RACF	Residential Aged Care Facility
RAD	Refundable Accommodation Deposit
RAP	Reconciliation Action Plan
RC	Residential Care
RCACQS /(ACRC)	Royal Commission into Aged Care Quality and Safety; Oftentimes referred to as the ACRC Aged Care Royal Commission
RN	Registered Nurse
SAHP	Support At Home Program
SIRS	Serious Incident Response Scheme
STRC	Short Term Restorative Care
TACP	Transitional Aged Care Program
UTS	University of Technology Sydney
UN	United Nations
WHO	World Health Organization

SECTION 1 – INTRODUCTION AND LITERATURE REVIEW

1. INTRODUCTION

1.1 "Rather Be Dead": Lived Experiences of Residential Aged Care in Australia

> Terrible. There's a shock when you move into aged care. There is a shock of loss because what happens is it is so quick. There's not the recognition of loss because loss is not just death. Loss is loss of your way of life. (Merle Mitchell Royal Commission into Aged Care Quality and Safety, 2019, p. 25)

In October 2018, the Australian Government called the Royal Commission into Aged Care Quality and Safety (RCACQS) because of scandals and sustained negative media associated with poor care (Connelly et al., 2018; Thomson et al., 2022). A royal commission is an independent public inquiry, called in Australia only under rare and exceptional circumstances, to investigate matters of significant public concern. It has broad powers to gather evidence, including summoning witnesses and requesting documents, and can determine causes, assign accountability and recommend changes to laws and policies. Over the course of its hearings and deliberations into quality and safety, the commissioners heard first-hand witness testimonies, and ran townhall sessions across Australia, to gather an understanding of the systematic nature of the problems and failures in quality and safety in aged care. While there are many salient examples in the literature, and the above-mentioned royal commission and other reports, Merle Mitchell's testimony in particular captured the negative experiences of so many people in aged care, nationally and internationally, and stressed the urgent need for change.

Merle had entered residential care following a fall which resulting in spinal fractures. Merle, fell whilst visiting her chronically ill husband, Eric. Initially they were seeking residential care for him. As a result of her fall, both Merle and Eric entered residential care together. In her earlier life she had been a wife and CEO of a social services peak agency. In her evidence, Merle spoke about the loss of autonomy, independence and personal choice regarding basic activities of daily living when she moved into residential aged care:

> I have to follow what the institution wants the time to get up, the time to have meals and there's no choice, so you lose your choice totally when you come into aged care and *that's one of the* things that needs to change. (Merle Mitchell Royal Commission into Aged Care Quality and Safety, 2019, p. 30)

Merle described the indignity associated with daily living and how staff treated people:

> I saw a staff member the other day sit on the table and shovel the food into the person's mouth, and she was yawning at the same time and not bothering to talk to him about what he was being fed. (Merle Mitchell Royal Commission into Aged Care Quality and Safety, 2019, p. 30)

Merle's loss and reduced quality of life were further demonstrated in not being able to access her belongings. Despite the residential aged care facility being called a home, she reported that her experience felt the opposite, given the lack of access to life, people and things she wished to access:

> It's an institution and it's where you live but it's not a home and no matter how many times they tell you, it's still not your home. So my answer always to anyone who tells me that is "This is where I live but it's not a home… I haven't got my own things around me … there's just that feeling that this isn't the proper life and so there is that feeling that the quicker it's all over the better. … I know I'm here until I die, so every morning when I wake up, I think, 'Damn I've woken up.'" I am sure if you asked most people here, they would all say they would rather be dead, rather than living more, if they're honest. (Merle Mitchell Royal Commission into Aged Care Quality and Safety, 2019, p. 5)

Merle's comments about wanting to hasten death due to a lack of quality of life and care–highlighted by the Royal Commission into Aged Care Quality and Safety–reflected the broader reality faced by many older Australians living in aged care services. Indeed, the commissioners stated in their final report that quality and human rights were synergistic, as follows: "Many people receiving aged care service have their basic human rights denied. Their dignity is not respected, and their identity is ignored." (Royal Commission into Aged Care Quality and Safety, 2021, p. 12)

Merle's testimony about her lived experience, equally compelling and confronting, highlighted a disconnect between the legislative frameworks governing Australian aged care services and

the models of care that are available to enhance the lived experience and quality-of-care provision.

1.2 Person-Centred Approaches to Enhancing Aged Care Experiences

1.2.1 Person-Centred Care

Person-centred care (PCC) is an approach to care provision that prioritises the unique needs, preferences and values of the person. PCC is predicated on the belief that the person and their family should be involved in decision-making processes, to tailor services in accordance with their needs and preferences. For the purposes of this study, the definition of person-centred care drew on the notable work of Tom Kitwood, who defines personhood as "a standing or status that is bestowed upon one human being, by others, in the context of relationship and social being. It implies recognition, respect and trust" (Kitwood, 1997, p. 8). Although originally developed for dementia care, this definition is based on the belief that every individual has inherent value and that people are always connected to others—such as their family members and residential care staff—instead of existing in isolation (Brooker, 2022; Dewing, 2004; McCormack, 2004; Nolan et al., 2004). In the context of gerontology and aged care, Kitwood's (1997) definition of PCC is highly regarded and widely accepted (Edvardsson et al., 2010; McCormack, 2004; McCormack et al., 2015; McCormack et al., 2012).

Person-centredness is regarded as one of the six tenets of quality care provision by the World Health Organization and the Institute for Healthcare Improvement in the United States and is enshrined in the Australian regulatory standards. But while agreed by these peak agencies, it is also the cause of much debate (Brooker, 2003; de Silva, 2012; Dewing & McCormack, 2017; Nolan et al., 2004). Yet, person-centred care has been promulgated as a way to enhance care provision, and it has been enshrined within the policy settings for aged care in Australia and many other countries. This is described in detail in Chapter 2.

1.2.2 Australian Approaches to Improving Aged Care Experiences

During this study, it became clear that Australia's aged care system, particularly residential care settings, had been and was still facing a crisis of quality (Baldwin, Chenoweth, Rama, et al., 2015; Smith et al., 2018; Wells et al., 2019). Despite existing policy and regulatory frameworks

aimed at ensuring high standards of care, and available person-centred care models, there remained a significant gap between these ideals and the lived experiences of older Australians (Sturmberg & Gainsford, 2019, p. 803). This disparity has been highlighted by media scrutiny (Thomson et al., 2022) and the Royal Commission introduced above and was exacerbated by the COVID-19 pandemic. The United Nations Principles for Older People (1991) affirm that older individuals have the right to independence, participation, care, self-fulfilment and dignity. However, evidence reveals that these rights are often not realised in residential aged care settings in Australia (Duckett & Stobart, 2021; Duckett et al., 2020; Petriwskyj et al., 2014).

Australia's prevailing policy and legislative frameworks have sought to enhance the quality of service provision and its aged care policies have espoused and enshrined "person-centred care", with choice as a central tenet of the *Aged Care (Living Longer Living Better) Act 2013* (Cth).

Furthermore, Australian aged care providers have sought to implement various models of care, drawing from international examples, to enhance quality of care and quality of life (Edvardsson et al., 2010; Gnanamanickam et al., 2018; Larkey, 2022). Despite these sustained efforts and attempts, however, numerous reviews, including the RCACQS, continue to highlight that quality of life and care remain elusive and inadequate (Holmes et al., 2018; Ibrahim, 2018). Quality of life and quality of care are human rights, yet the RCACQS reports (and other evidence, examined in Chapter 3, confirms) that this ideal remains unrealised.

Persistent quality failures in aged care, despite the promotion of person-centred care in government policy and the regulatory pillars, reveal systemic issues (Baldwin et al, 2015 Ibrahim, 2018, Ibrahim, 2019). This cyclical pattern culminated most recently with the highest level of inquiry, namely, the Royal Commission into Aged Care Quality and Safety, called by the Morrison government in 2018. It was here that the commissioners concluded that the aged care system was transactional and continued to depersonalise older people.

> As a nation, Australia has drifted into an ageist mindset that undervalues older people and limits their possibilities, Sadly, this failure to properly value and engage with older people as equal partners in our future has extended to our apparent indifference to aged care services. (Royal Commission into Aged Care Quality and Safety, 2019b, p. 1)

These legislative initiatives and policy assumptions set the scene for the modern aged care system we know today with various models being promulgated and implemented to enhance quality of care and life. Yet, as the quote from the RCACQS highlights, at all levels we continue to perpetuate the narrative of old age as a problem, we fail to value older people and we compromise their right to quality care and life (Ibrahim, 2019; Royal Commission into Aged Care Quality and Safety, 2019b).

During the RCACQS, the two commissioners heard evidence from several experts on what high-quality person-centred care meant and they conducted round-table sessions on models of care in use and capable of enhancing quality of life and care. In their final report, the commissioners recommended that "high quality care must be the foundation of aged care in Australia" and that the Australian aged care needed to move to "relational person-centred care" (Royal Commission into Aged Care Quality and Safety, 2021, p. 71). Since that was what the policy settings and legislative pillars had been designed to support, these recurring quality failures, often highlighted by the media and followed by cycles of reviews and reports, underscored the challenges of implementing meaningful change within a complex system.

1.2.3 International Approaches to Implementing Person-Centred Care Models

Australia is not unique in seeking to improve and deinstitutionalise aged care practice. Several studies have highlighted that the medicalised model of care has been insufficient to meet the needs of older people (Armstrong et al., 2019; Power et al., 2010; Sinha et al., 2025; Thomas, 1996) and that it is "plagued" with poor outcomes and dreaded by older people and their families as a model of care (Cullen, 2003; Gilbert, 2002; Henderson & Willis, 2019).

Given this complexity and concurrent desire to challenge the medicalised model of care and enhance quality of life for people living in residential aged care, various groups have developed and promulgated models specifically for residential care, notably, the "Eden", "Green House", and "Household" models in the US, "Humanitas" in the Netherlands, and "My Home Life" in the UK. Providers in Australia have subscribed to and used these models. South Australia conducted a pilot with "My Home Life" and Uniting NSW. ACT has implemented "Household" models, (Ahmed et al., 2019; Carnemolla et al., 2021; Shields & Norton, 2006) and both MiCare and Wesley Mission, Queensland, have implemented the Eden model (Larkey, 2022; Thomas,

2003). These "subscription/proprietary-based" models have been used in the Australian context to support a more PCC lived experience, and other providers have developed their own bespoke models of PCC. Chapter 2 provides an overview of the various models, with a number of the thought leaders involved in the inception and implementation of the models interviewed as part of the qualitative stage of this study, discussed in Chapter 6.

The rationale for these models is that older people's experience in aged care is characterised by boredom, loneliness and helplessness, all of which adversely affect quality of life and meaning loss, reportedly perceived as the norm for elderly residents (Aronson, 2019; Baars & Phillipson, 2013; Power, 2010; Robertson, 2019; Thomas, 1996). To challenge this paradigm, a number of models and a social movement, called "Culture Change" commenced in the USA have had an impact across many western countries (Corazzini et al., 2016; Dyer et al., 2019; McCormack et al., 2012; Rahman & Schnelle, 2008; Ronch, 2004). "Culture change", in the US context, refers to a broad shift in care provision, aiming to transform traditional, biomedical models of care into those that are more person-centred, that prioritise quality of life and care in homelike settings. There are global consortia of researchers who continue to explore these models, for example, the We-Thrive group led by Professors Corazzini and Lepore (Corazzini et al., 2019; Wang et al., 2021).

1.3 Australian Policy Language and Terminology

Two interconnected themes have run through aged care scholarship and policies, typically seen and reviewed separately. These themes are "person-centred care" for enhanced quality, representing a shift from biomedical models focused on disease and deficit, and "consumer-directed care", which emphasises choice and control (Brennan et al., 2012; Davidson, 2011). Both are driven by person-centred approaches, presumption of capacity and individual autonomy (Fine & Davidson, 2018). They propose that individuals should be able to choose the care they want, and where and how they want it and they were the impetus for some providers to evaluate their models of care and seek to change (Henderson & Willis, 2019).

The language used in policies and scholarly literature – e.g., "patient", "resident", "consumer" – keeps changing, and indeed the definitions of these terms often remain uncertain (Costa et al., 2019). In the *Aged Care Act 1997* (Cth), older people who receive care are referred to as "care

recipients". This Act was one of the first major policy changes of the Howard Liberal government, which restructured and changed the shape of the Australian aged care sector. It shifted the language of "hostels" and "nursing homes" to "residential aged care facilities" (RACF). In 2013, the terminology referring to older people changed again. Following the findings of the Productivity Commission's *Caring for Older Australians* report (Productivity Commission, 2011), the Aged Care (*Living Longer Living Better, (LLLB) Act 2013* (Cth), an amendment to *the Aged Care Act 1997* (Cth) referred to older people as "consumers", enshrining the central tenets of choice and control (Aged Care Quality & Safety Commission, 2020; Moore, 2021; Nay, 2014).

The multiplicity of terms in use, their associated ambiguity and their implications for practice came to represent an emerging area of scholarly inquiry (Baines & Armstrong, 2018; Karlin et al., 2006). Literature highlights the importance of considering these terms in relation to their intersections with the culture and quality of aged care (Barbato & Feezel, 1987; Petriwskyj et al., 2014) and their utility in supporting or adversely impacting organisational enablers of culture change (Petriwskyj, Parker, et al., 2015; Tuckett, 2006; Wasserman & McNamee, 2010).

These changing terms and how they manifest with regards to implementation and the realisation of person-centred models in practice were a catalyst for this study. What are the distinctions between the different terms used to describe older people? Could they be the primary or a significant factor in addressing the challenges, such as those presented in Merle Mitchell's evidence, and those affecting the sector in ways that resulted in its evident failures?

During this study, and particularly between 2021 and 2025, the aged care sector in Australia was undergoing significant reform. In the wake of the Royal Commission (RCACQS), there was a renewed focus on the role of language in shaping care. Could the terminology used in policy and legislation, and its intersection with practice, be a major factor in achieving meaningful change? Examining the terms used to describe older people may offer valuable insights into how person-centred care models are implemented in practice. It is therefore worth asking: does the way people are referred to in policy and legislative documents differ from, and potentially influence, the language of care and personhood in everyday practice?

1.4 Rationale and Aims for this Study

1.4.1 Embedding Personal and Professional Experience

This researcher’s background in aged care, including executive leadership in clinical governance and cultural transformation, provided a critical context for this study. From these professional experiences, I understood that contemporary models of care sought to improve experiences like Merle’s. Yet it was also clear that major challenges were associated with leading and implementing change in practice to achieve these goals. This study is the consequence of questions and insights associated with leading this work, and my personal experiences with aged care services for my own parents. These experiences left me asking, “Why is the implementation of person-centred care so difficult, despite the high motivation to do so?” This thesis drew on these personal and professional experiences, uncovering the disconnect between policy language and practitioner language and practice in the implementation of person-centred models.

1.4.2 Research Aims

This research aimed to examine how the language and terms contained within Australian aged care policy, as outlined in Chapter 3, influence the implementation of person-centred care and other change models to enhance the quality of care and quality of life of people living in residential aged care. To enhance quality, we need to understand whether terminology and language are potential keys that impact PCC implementation and the lived reality for people living in aged care.

Through explanatory sequential mixed methods, with data drawn from Leximancer analysis of government reviews and policy, interviews and site visits, this research sought to address the primary research question:

- How does policy language influence the implementation of person-centred care models in Australian residential aged care?

This was addressed by the following research sub-questions:

1) What are the key language and terminology shifts in aged care policy reviews 2011-2021? (chapters 3 and 5)
2) What are the perspectives of aged care leaders with regards to implementing person-centred care models in residential aged care? (Chapter 6)
3) How do aged care leaders perceive the relationship between legislative and policy terminology, and the implementation of cultural change in residential care services? (chapters 6 and 7)
4) How can international perspectives inform our understanding of implementing culture change and compare to the Australian context? (chapters 6 and 7)

The remainder of this chapter provides the background for this research, clarifying key terms, including what is meant by "quality of care", "person-centred care" and other models, and their connection to language, culture and safety.

1.4.3 A Mixed-Methods Approach

This study used an explanatory sequential mixed methods design to critically examine organisational strategies for cultivating person-centred cultures within the Australian residential aged care sector. It investigates the shifting policy frameworks and legislative obligations governing aged care delivery, with particular attention to how these frameworks shape and constrain implementation practices. The study draws on interviews with national and international executives and thought leaders to identify the structural, cultural and operational factors that facilitate or hinder the adoption of person-centred care models. It explores the rationale behind organisational decisions to implement specific models of care aimed at enhancing the quality of life and wellbeing of aged care recipients.

The study examines whether the use of language and terms such as "*customer/ client/ consumer"* used to define people who receive care, contributes to systemic misalignments between policy intent and practice, and whether it played a role, however minor, in the failures exposed through media investigations and the RCACQS. In addition to qualitative interviews, the study undertakes a comprehensive analysis of relevant policy documents and commissioned review reports to contextualise the evolution of sector-wide reforms and their implications for person-centred care.

A variety of terms is used to refer to where older people receive care (Howe et al., 2013). This study focuses on what is called "residential aged care" in Australia (Milte et al., 2018; Trigg, 2018) or "long-term care" in other countries, such as the USA or Canada (Armstrong et al., 2019; McCormack et al., 2012). The Australian government characterises "residential aged care" as "residential aged care facilities" (RACF) that provide 24-hour care and accommodation for older people who are unable to continue living independently in their own home and need assistance with everyday tasks" (*Report on the Operation of the Aged Care Act 1997*, p. 3). The Australian definition aligns with the Organisation for Economic Co-operation and Development (OECD) definition regarding long-term care as "care for people needing support in many facets of living over a prolonged period of time" (Ariaans et al., 2021, p. 610; Colombo et al., 2011, p. 11; OECD, 2025, p. 1).

1.4.4 Thesis Structure and Layout

This thesis is structured in four main sections, comprising eight chapters. It uses the following schematic illustration based on the work of Braithwaite, (Braithwaite, 1999).

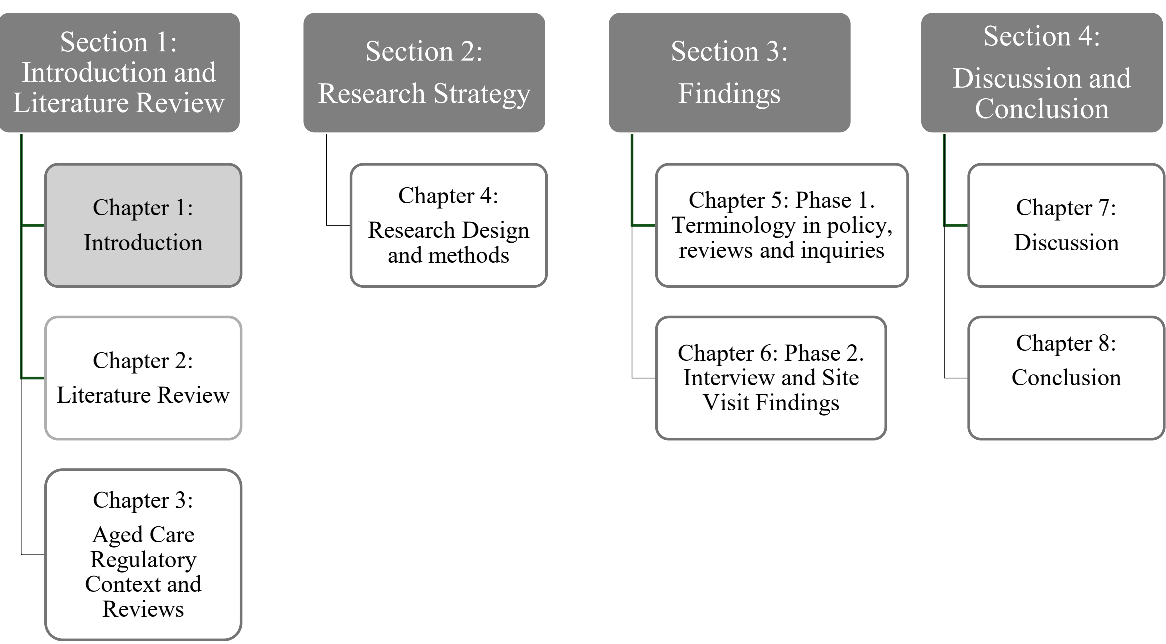


Figure 1 Thesis Outline Chapter 1

As the thesis progresses, this illustration changes, with each chapter under discussion highlighted/ shaded at the beginning of the chapter to situate the reader.

This first section comprises this introductory chapter, the literature chapter (Chapter 2) and a contextual overview of the legislation that underpins Australian aged care delivery (Chapter 3). Chapter 2 reviews the extant literature that underpins the concept of person-centred care and the various models that providers use in practice; it highlights how systematic reviews of the change models have questioned the implementation process, which is a key focus of this study. The chapter then concludes with the results from the literature review on the use of the term “consumer” as it relates to change and aged care. Chapter 3 provides a contextual overview of aged care in Australia, including the history and role of inquiries to examine quality failures and inform policy.

The second section of this thesis, comprising Chapter 4, presents the research methodology, outlining the empirical foundations of the study, the ethical considerations, the explanatory sequential mixed-methods design, methods of data collection and analysis. This chapter will also outline the necessary COVID-19 adaptations and protocols required as a result of the pandemic. It will also highlight the impacts on the study design, notably site visits and observation that were intended. Section 3 comprises the two findings chapters associated with the empirical research that used explanatory sequential mixed methods. Chapter 5 presents the Phase 1 findings from the Leximancer quantitative analysis of the five national reviews and reports, and Chapter 6 presents the Phase 2 findings from the qualitative arm of the study, including site visits and observations, the impact of COVID-19 restrictions and public health protocols to protect Older Australians living in residential aged care.

The fourth and final section synthesises the findings and meta-inferences from the preceding chapters, focusing on how terminology and language, both implicit and explicit in policy, influence the implementation of person-centred models in residential aged care settings. Chapter 7 offers an interpretation of the findings using an abductive approach informed by a Bourdieusian theoretical lens. The concluding section of the thesis, presented in Chapter 8, discusses the study’s implications, outlines its limitations and provides recommendations for future research.

1.5 Conclusion

This opening chapter has provided the backdrop and positioning of this thesis within the context of Australian aged care. It has highlighted the need to enhance quality of care and quality of life through the implementation of person-centred care models and it presents the aims, rationale and significance of the thesis. The next chapter in this opening section will examine the empirical literature as it pertains to the research questions.

2. Literature Review

2.1 Introduction

Words define us, they explain us, and on occasion, they serve to control or isolate us. But what happens when words that are spoken are not recorded? What effect does that have on the speaker of those words? (Williams, 2022, p. 405)

The previous chapter set the context for the study, highlighting approaches adopted to enhance the quality of life and quality of care of people in residential aged care from both a policy and practice perspective. A thorough review and analysis of historical policy development shows that the use of models designed to enhance practice have been inadequate, with limited improvement in the experience for older people’s lives in residential aged care.

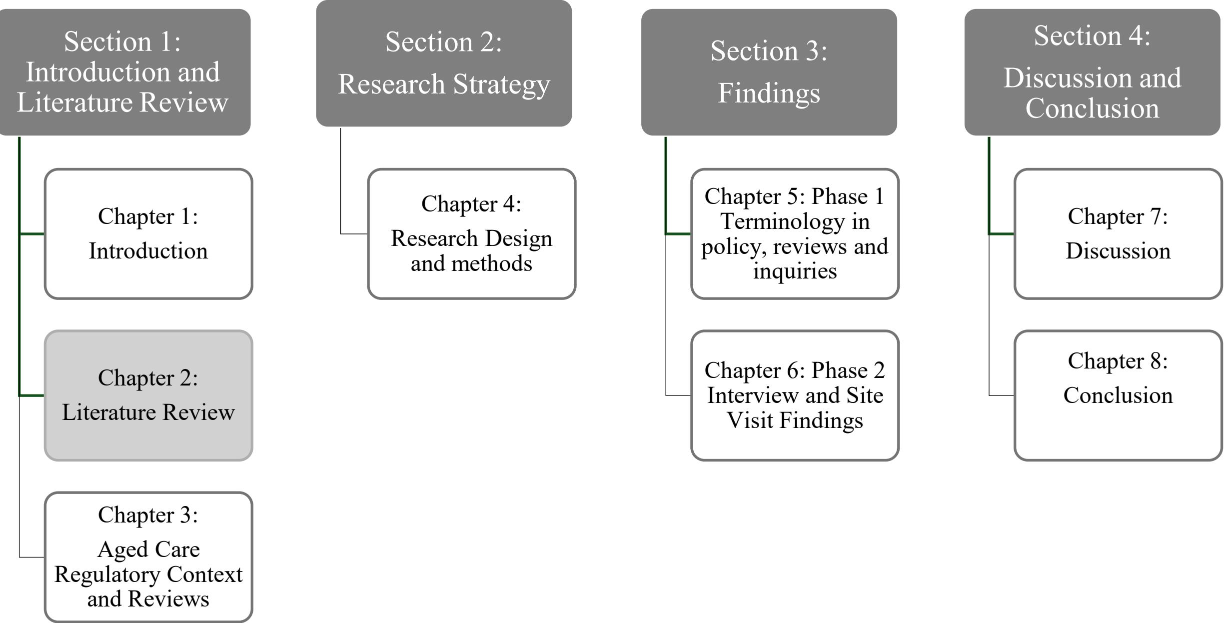


Figure 2 Thesis Outline Chapter 2

This second chapter continues with the contextual introduction, exploring the literature on person-centred care models and how these are implemented within aged care settings. It begins with a conceptual analysis of key constructs and an overview of the different types of person-

centred care models. The chapter then presents a scoping review of the literature on person-centred model implementation in aged care, providing a systematic foundation for investigating current implementation approaches to enhance the quality of life and quality of care for older people in residential care settings. This critical analysis of existing research reveals significant patterns in implementation practices, which shaped the research questions and methodological framework for this study.

2.2 Types of Person-Centred Care Models and Experiences of Implementation

Merle Mitchell’s lived experience and the RCACQS commissioners (see Chapter 1) highlighted that quality of care and quality of life are human rights (section 1.1). Understanding the depth of these rights as laid out in the statement from the United Nations Principles for Older People (1992) underscores the importance of this topic. The United Nations General Assembly (UNGA) ratified 18 principles for older people in society. Included in these principles were the right to independence, participation, care, self-fulfilment and dignity (United Nations, 1991). There have been ongoing plans to support, uphold and enshrine these rights (Brock, 2025; Harper, 2025; Herro, 2017; Kohn, 2025). However, even with these rights, models and legal frameworks in place, aged care quality has been considered so systemically poor that in 2018, a royal commission into aged care quality and safety was instigated in Australia by Prime Minister Scott Morrison.

To understand the role of quality in aged care receipt and delivery, it is important to return to first principles and understand the key terms (“quality” and “person-centred”) and their interrelationships. “Quality” in health, aged and/or social care is widely accepted, albeit as a multidimensional and subjective concept (Berwick & Knapp, 1987; Donabedian, 1979). The World Health Organization (WHO) (2018) describes quality in healthcare according to six dimensions: safe, effective, timeliness, efficient, equitable and person-centred. Person-centred care is defined as:

> … approaches and practices that see the person as a whole with many levels of needs and goals, with these needs coming from their own personal social determinants of health. (World Health Organization, 2015, p. 5).

In its seminal work *Crossing the Quality Chasm*, the Institute of Medicine (IOM) (2001) in the USA determined that PCC was unpinned by qualities of "compassion, empathy, and responsiveness to needs, values and the expressed preferences of the individual" as foundational to quality care provision (Committee on Quality of Health Care in America, 2001, p. 48). While person-centredness represents only one dimension of quality, it has become increasingly synonymous with high-quality care provision (Churruca, Long, et al., 2023). The following section explores the concept of PCC in greater depth, examining its relevance and application in the context of this study.

2.3 Person-Centred Care

This brief philosophical overview is important to the central tenets of this study and implementing PCC models. PCC originates from a philosophical perspective and has been a leitmotif in the extant literature for the latter part of the 20th century and the gold standard for quality care (Dewing, 2004; Dyer et al., 2018). Most authors agree that person-centredness is predicated on a humanistic tradition (McCance et al., 2011) which centres the person and their inherent worth, based on the philosophical tenets of Kant's (McCormack, 2004), Buber's (McCormack et al., 2012) and Rogers' (1951) approaches to client centred therapy. The core elements of these are unconditional positive regard, empathy and congruence, grounded on principles of genuineness and acceptance of the person's basic worth (Rogers, 1951).

PCC is an approach to care provision that prioritises the unique needs, preferences and values of the person–"a standing or status that is bestowed upon one human being, by other in the context of relationship and social being. It implies recognition, respect, and trust." (Kitwood, 1997, p. 8). As introduced in the previous chapter, Kitwood's definition is based on the belief that every individual has inherent value and that people are always connected to others–such as their family members and residential care staff–instead of existing in isolation (Brooker, 2022; Dewing, 2004; McCormack, 2004; Nolan et al., 2004).

Kitwood challenged the prevailing attitudes regarding a deficit mindset towards older people and the depersonalisation he witnessed and described as "malignant social psychology" (Kitwood, 1997; Kitwood & Brooker, 2019). Kitwood's work, with its focus on relationships and on the aspects of recognition and respect in the context of status being bestowed by others,

has been particularly influential in informing this current study. Kitwood identified five psychological needs attachment, comfort, identity, occupation and inclusion built on love. He also advocated for the provision of more humane environments and "small houses" to challenge the normative practices of "warehousing" older people and treating them as outcasts (Kitwood, 1997).

While the introductory chapter of this study has provided the underpinning definitions for PCC and quality at a theoretical, macro level (see Chapter 1, section 2.1), these multidimensional concepts can be more difficult to define and implement in practice settings. In seeking to understand quality in aged care, it is important to understand these two aspects of quality, "quality of care" and "quality of life", as they are central to each resident's experience in residential aged care, their "homes" (Cleland et al., 2021; Milte et al., 2016; Trigg, 2018). To understand this further, it is helpful to draw on international literature as it pertains to quality, PCC and models developed to implement and realise them in practice.

2.3.1 International Approaches to Implementation: UK and US Experiences

An overview to implementing person-centred care models provides an essential background to the analysis of interview data (see Chapter 6) and to answering research sub-question 4, "How can international perspectives inform our understanding of implementing person-centred care models and compare to Australia?" In the US, person-centred models are sometimes referred to as "small house" models and "culture change" (McCormack et al., 2012; Sinha et al., 2025). In the UK, My Home Life is predicated on a "relationship-based" model of care (McCormack et al., 2012). Extensive scholarly debates exist regarding the interrelationships, similarities and differences between a relationship-based model and a person-centred care model (Dewing, 2004; Dewing & McCormack, 2017; Edvardsson et al., 2010; Lines et al., 2015; McCormack et al., 2012; Nolan et al., 2004).

2.3.2 The USA Experience: Person-Centredness as a "Culture Change" Movement

As early as 1985, the National Citizens' Coalition for Nursing Home Reform, an advocacy group concerned about substandard care in USA nursing homes, developed a statement of principles that enshrined residents' rights (Holder & Frank, 1985). This statement of principles was endorsed by key stakeholders, including the Department of Health and Human Services

and the US regulatory body. This interdisciplinary group along with the funding body, the Centre for Medicare and Medicaid (CMS) and the American Association of Retired Persons (AARP), conducted resident focus groups. These residents stated that the two concepts of "quality of care" (clinical treatment and physical care associated with activities of daily living) and "quality of life" (how one is treated, privacy, dignity, etc) were inseparably linked (Koren, 2010). These definitions were integral to the recommendations contained in the IOM report *Improving the Quality of Care in Nursing Homes* (Committee on Nursing Home Regulation, 1986) which underpinned the USA *Omnibus Reconciliation Act* 1987 (Popp, 2018). Both the report and the new Act stipulated that residents must receive "quality care" **and** that the "home" aspect be amplified for enhanced "quality of life" (Kelly, 1989).

Koren (2010) states that US law specified that nursing home residents "be provided with services sufficient to attain and maintain his or her highest practicable physical, mental, and psychosocial well-being" (p. 2). Koren further points out that these stipulations regarding quality were the first part of the US health economy to do so from a statutory perspective and they became synonymous with person-centred care (Koren, 2010, p. 2).

Culture Change Movement

The policy context changes described above were a catalyst for a number of providers, individuals and residents to challenge the norms of the biomedical aged care delivery model. Key leaders in the USA-promulgated models, such as Eden (Thomas, 1996), Green House (Thomas, 2003), Wellspring (Stone et al., 2002) and Household (Shields & Norton, 2006) sought to transform the aged care landscape into households, giving rise to the culture change movement in aged care. Two groups in the USA, the Pioneer Network and the Green House Project[1], are noted for leading and promoting these alternative approaches to both care environments and the associated practice requirements to realise these models, A number of these models have been implemented in other nations such as Canada (Armstrong et al., 2019; Sinha et al., 2025), the UK (Ahmed et al., 2019) and Australia (Larkey, 2022), and in other locations around the globe, (Power, 2010; Yeung & Rodgers, 2017).

[1] The Pioneer movement and the Green House project merged in 2022 and the new entity became known as the Centre for Innovation (Center for Innovation Announces Combined Leadership Structure - Green House Project). A further name change to AgingIn™ occurred in 2025

A number of studies have been critical of these models for the lack of evidence of the changes and the claims associated with the enhanced quality of life that they claimed (Rahman & Schnelle, 2008). One criticism is that there have been no agreed definitions as to what constitutes culture change (Koren, 2010; White-Chu et al., 2009) and nor has there been consensus about what the ideal nursing home configuration looks like (Koren, 2010; White-Chu et al., 2009). These inconsistencies will be unpacked further, with a closer examination of "small house" models, in the next section (Small House Models).

In her review of the definitions of culture change over almost two decades, Carson determined that it involved 14 operational definitions (Carson, 2015). This is consistent with earlier findings where culture change was deemed to defy easy definition (Rahman & Schnelle, 2008). In the continuing spirit of first principles, The Pioneer Network defined culture change thus:

> "Culture change" is the common name given to the national movement for the transformation of older adult services, based on person-directed values and practices where the voices of elders and those working most closely with them are solicited, respected, and honored. Core person-directed values are relationship, choice, dignity, respect, self-determination, and purposeful living. (Pioneer Network, 2022 n.p.)

This definition appears to encompass the breadth of Kitwood's definition and the UN Principles.

Small House Models

While not endorsing specific models, Pioneer Network members agreed that the ideal residential aged care facility or nursing home should embody the following elements to enhance quality of life and care: resident direction, a homelike atmosphere, close relationships, staff empowerment, collaborative decision-making and quality improvement processes. These elements were co-designed and endorsed by key stakeholders, advocacy bodies, government and regulatory agencies, providers and trade associations. The Pioneer Network explicitly defines a small house model as:

> *A small group of residents living within a physically defined environment that "feels like home" and that has a kitchen (with a wide variety of food accessible to residents around the clock, including breakfast-to-order and on demand), a dining room and a living*

> *room. Staff are consistently assigned so they can develop meaningful relationships with the residents, work in self-led teams and perform a variety of tasks. The sense of being at home is expressed in recognizing and honoring the rhythm of each individual's life. All residents in the household have opportunities to participate in the daily life of the household in a manner and to the extent they choose. (The Pioneer Network 2022 n.p.)*

Both the Pioneer Network and Grant and Norton (2003) identified several common elements that are required to move from an institutional model of care to a small house model (SHM). All of these elements are in direct conflict with the typical command-and-control model associated with an institutionalised or medical model of care delivery (Sheard, 2014; Shields & Norton, 2006). These elements are listed below.

- *Space* – clear delineation between, public, semi-private and private, single rooms, ensuites and a defined number of residents within each area. They become more personalised and self-contained.
- *Kitchen* – a domestic kitchen with opportunity for residents to participate, where food is freely available and can made to order.
- *Bathing or showering* when the person chooses.
- *Staffing* models change to consistent assignment, to enable more meaningful relationships and interactions. Staff are cross-trained.
- *Decision-making* – in addition to consistent assignments, implicit to the model is that staff are self-directed, with devolved decision-making and authority.
- *Organisational redesign* – underpinning the above elements, there is a shift to break down silos and hierarchies to become more multidisciplinary.
- *Leadership and culture* – finally, a focus on mindsets and attitudes to support PCC and the model in both philosophy and practice.

2.3.3 The UK Experience: My Home Life as "Relationship-Centred" and Person-Centred Practice

The UK has had a rich history of person-centred model development with researchers such as Kitwood 1997) and his definition and work extended by Brooker (2022). Equally, McCormack, who has written extensively on this topic, together with McCance, developed the person-centred

care framework (McCance & McCormack, 2017; McCormack, 2004; McCormack et al., 2010) and practice development schools to support implementation.

However, there has been debate over the perception that person-centredness as a model is silent or ambiguous on the aspect of relationship, resulting in other models of care being developed, such as The Senses Framework (Nolan et al., 2006; Nolan et al., 2004). From a definition aspect, McCormack and Dewing sought to counter this pluralism and the associated debates with a number of papers and editorials (Dewing & McCormack, 2017; McCormack, 2022) These debates about model heterogeneity and the ensuing papers have informed this study (McCormack et al., 2012).

Similar to the PCC and The Senses Frameworks described above are such models as the Butterfly model developed in the UK (Sheard, 2014; Sheard, 2007), which focuses on dementia specific care approaches in small house settings (see **Table 2**). One of the most notable interdisciplinary developments to enhance residential aged/social care in the UK was that of My Home Life (Owen, 2006; Owen & Meyer, 2012).

A number of key stakeholders from a wide cross-section of aged care (called social care in the UK) including academics, regulatory agency, peak agencies, Department of Health policy personnel and consumer groups agreed to collaborate to enhance aged care provision for the new century. With new legislation and associated legislative changes, they sought to design a new model of care to address issues associated with quality of care and life failures and to restore trust in the UK social care system. This multidisciplinary approach resulted in a model based on research evidence (NCHR&D, 2007; Owen & Meyer, 2007) and evaluation frameworks and coaches to assist with the roll out. The resulting model, My Home Life (see **Table 2**) has had numerous evaluations conducted by the Joseph Rowntree Foundation (Owen & Meyer, 2012), has been used also in Northern Ireland and Scotland and supported by the various health departments in these countries. The model has been further extended with the Caring Conversations framework to support implementation of the model (Dewar et al., 2019; Dewar & Cook, 2014; Dewar & Nolan, 2013). The model has also been applied in Australia, with developers working with a number of providers in South Australia (SA) as an initiative of the SA Innovation Hub (*https://sainnovationhub.com/my-home-life*).

2.3.4 Summary of Models to Realise Person-Centred Care

A summary of care and practice models that help to enhance quality, wellbeing and personhood in residential aged care facilities is presented in **Table 2**. These are sometimes also referred to as small house models that realise person-centred care.

Table 2 Examples of Care Models for Implementing Person-Centred Care

Model	**Description**
Green House	The GH model is a trademarked model with structural, procedural and philosophical components defined by the national Green House Project, for example 8-10 people living in the Greenhouse, with consistent staff. The Green House model is based on three values—real home, meaningful life, and empowered staff (Bowers et al., 2016).
Eden Alternative USA	Developed by Dr Bill Thomas to challenge the perceived “plagues of aged care”, namely, loneliness, boredom and helplessness. Eden draws extensively from positive psychology and in particular wellbeing. Eden has been franchised for use in multiple countries, trading in Australia as Eden in Oz & NZ. Several providers in Australia use Eden to support their model of care. It has an accreditation process associated with its implementation and use.
Household model Action Pact	Developed by Norton, the change process or journey to home is predicated on the works of Senge, Prochaska and DiClemente. Highlighting that change is more than just the environment or facility, this model also requires changes in staff attitudes, roles and decision-making processes (Prochaska et al., 1994; Senge et al., 1999).
My Home Life (MHL)	The model is predicated on transformational leadership, action research with co-design and partnership, underpinned by the mantra “voice, choice and control” (Dewar et al., 2019; Owen & Meyer, 2012). MHL is used across all the jurisdictions of the United Kingdom and is regarded as a social movement for change in the care sector. The model is facilitated in practice settings with trained facilitators and works at various levels of the organisation to enable the change process.

Despite extensive research and model development, debate continues over the person-centred models in use and their theoretical underpinnings (McCormack et al., 2012). Following criticisms regarding the paucity of empirical evidence associated with the models being promoted and disseminated, many studies have been conducted over the ensuing years, with

research collaborations such as the WeThrive group across the globe emerging and conducting international multi-site studies.

Following this contextual overview, the chapter now progresses to its main point, the literature review method, and findings.

2.4 A Scoping Review: Implementation of Person-Centred Models

The overview of person-centred models above and my professional experience in residential aged care reveal inconsistencies in the evidence supporting implementation of person-centred care in the aged care sector. While operational challenges such as financial performance and staffing levels routinely compete with quality care delivery priorities (Baines & Armstrong, 2018; Baldwin, Chenoweth, Dela Rama, et al., 2015; Miller et al., 2014), the frequent modifications to government funding frameworks add another layer of complexity (Fine & Davidson, 2018). However, there are multiple barriers to implementation beyond these operational and funding factors, such as change fatigue, lack of motivation and change resistance (Gibbons, 2019). This raises fundamental questions about how effectively policy reforms and legislative changes translate into practice settings and models of care and to what extent these translations are examined in the existing literature. This scoping review critically analyses the interplay between policy changes and the practical implementation of person-centred models in residential aged care settings.

Using a scoping approach, the following literature review addressed the following objectives:

- To understand the existing knowledge on person-centred care model implementation, to improve quality of care and quality of life for residents in residential aged care settings.
- To understand the evidence regarding how quality, person-centred care transformation and implementation have been studied and reported in the aged care context.
- To determine if there were any gaps and opportunities for further research.

2.4.1 Method of Scoping Review

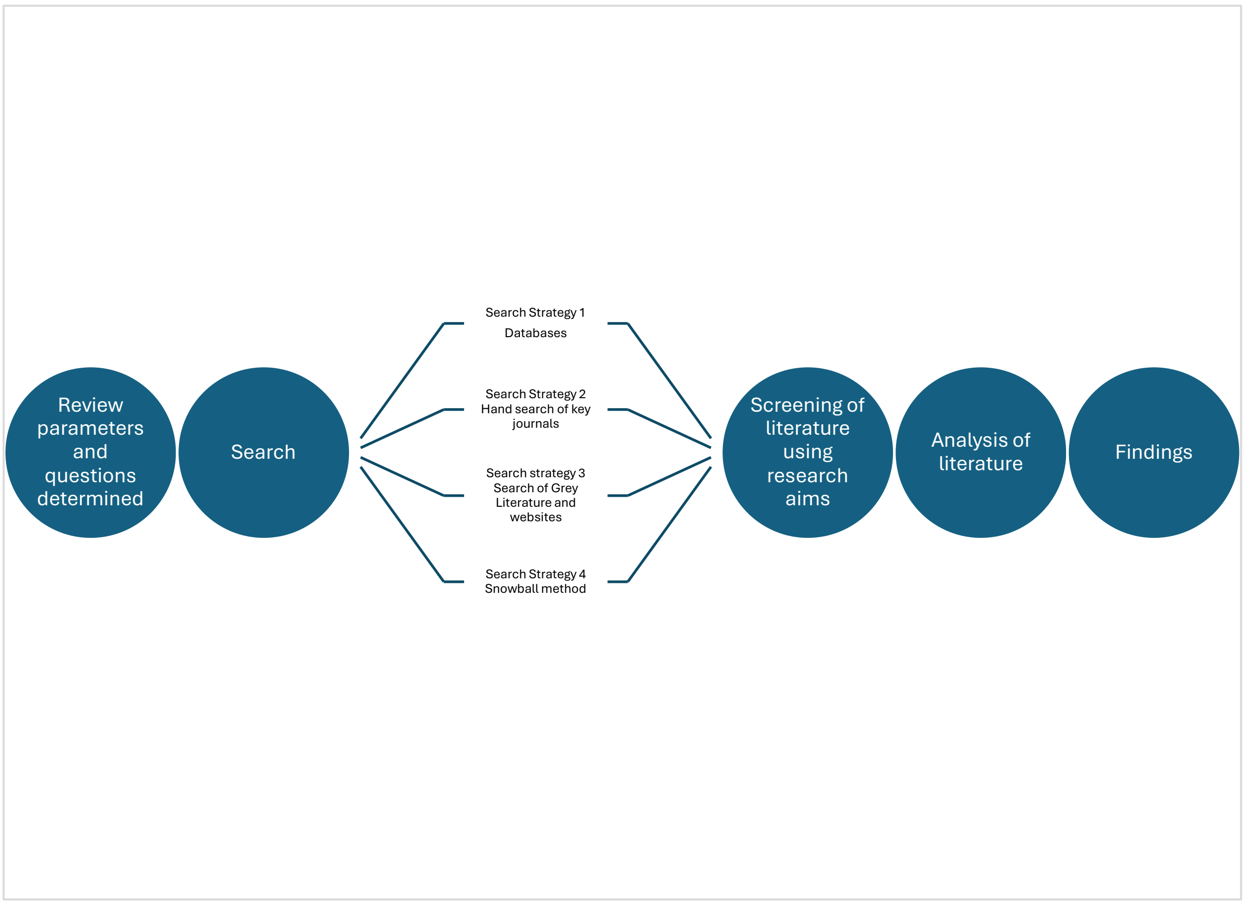


Figure 3 Literature Review Process

The scoping review for this thesis, was conducted using the systematic method depicted in **Figure 3** Literature Review Process with the resulting outputs across all phases provided in **Table 5**. Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Flow Diagram. Each stage to achieving this will now be outlined and will conclude with a discussion on the findings of the process as they relate to this study.

2.4.2 A Scoping Review of Systematic Reviews

There were four stages to the literature search so as to make it as wide as possible in informing the research questions. The rationale for this approach was that the databases covered the interdisciplinary aspect of the study questions and the snowballing reflected the dynamic and prolific nature of the RCACSQ, which provided a significant corpus of literature from which to draw. The search strategy was informed by an experienced librarian to ensure the search

approach was comprehensive and the terms and truncations were appropriate for the databases used. The literature was guided by and followed the approach outlined by Creswell (2009). The stages in the literature search are listed below:

1. Key papers known to the researcher were reviewed initially, with search terms and reference lists reviewed to assist with determining the search.
2. Four databases were used for the literature review. These were based on the key papers reviewed in step 1. These were Scopus, an interdisciplinary disciplinary database, CINAHL (nursing and allied health literature), PsychInfo via the EBSCO Host and MEDLINE via the Ovid Host.
3. Hand searching from government reports, key papers, grey literature and known literature from this researcher's previous experience.
4. Connected papers were used with key papers to cross reference other papers and ensure the broadest understanding of the topic.

The databases included in the search provided the best opportunity for the theoretical underpinning of this thesis and for the ways in which person-centred models and implementation were conceptualised and reported by each of the disciplines.

2.4.3 Search Terms and Criteria

Based on the research questions and awareness of the existing literature, search terms and criteria were devised with synonyms and spelling conventions to account for USA English and Australian English and for the nomenclature of the various ways in which aged care is referred to in other countries, for example, "long-term care" or "social care". Each of the models known to be in use was included. These were placed in columns and searched with "or" and then all three columns searched with an "and". Where medical subject headings (MeSH®) terms were allocated, these were used. "Exp" referred to a MeSH term (where allocated) that had been "exploded" for the widest possible capture of the term.

The initial search for key words (see **Table 3** below) used all the databases separately with appropriate Boolean shortcuts for US and Australian English. Each search was conducted with an experienced health librarian to ensure the highest quality search across all stages.

Table 3 Search Terms

"person-cent#red care" OR "patient-focused care" OR "resident-cent#red care" OR "customer-cent#red care' OR "client-cent#red care" OR "consumer-cent#red care" OR "relationship-cent#red care" AND "Aged care" OR "Residential w/3 aged care" OR "long-term care" or "residential w/3 facilities" OR "social care" OR "Nursing home" OR "housing w/3 elderly" OR "Eden Alternative" OR "household model" OR "greenhouse model" OR "My home life" OR "small house model*" "Quality of life" and "Culture Change".*

Specific inclusion and exclusion criteria were determined to review the search results. These are listed in **Table 4**.

Table 4 Inclusion Exclusion Criteria

Inclusion Criteria	**Exclusion Criteria**
• People over 65 years old • Residential, social or long-term care settings • Countries Australia, Canada, USA, UK, Ireland and New Zealand. • Ideally systematic or scoping review • Published after 2010	• People younger than 65 • Outside residential aged care, i.e., hospital or geriatric wards • Not in English • No abstract • Published before 2010

2.4.4 Search Process

Each database was searched separately with the same search string, thus providing consistency to the search. The results from each search were imported into Endnote x9.0 (Clarivate). Duplicates were then removed from the search. The full set from each search was imported into Excel for further analysis and review. From this first analysis, the literature was reviewed and any anomalies with the search or overlaps detected. A series of steps then followed as per the PRISMA process (Page et al., 2021; Sarkis-Onofre et al., 2021) to ensure as complete and accurate a review as possible.

2.4.5 Hand Searches of Journals

A number of core journals were hand searched for relevant articles. These were *The Gerontologist, Australasian Journal on Ageing, Journal of Gerontological Nursing, Age and Ageing, BMC Geriatrics, International Journal for Quality in Health care, Quality in Ageing*

and Older Adults, Clinical Gerontologist, BMJ Quality and Safety, Journal of Clinical Nursing and Journal of Advanced Nursing. Alerts were established with ResearchGate and each database. In addition, I subscribed to weekly notifications from the Clinical Excellence Commission newsletter, *On the Radar*, which collates articles on safety and quality from a diverse range of journals and is circulated by email every week. Reviewing this enabled me to quickly review relevant articles.

2.4.6 Snowball Method

Snowball searching was conducted by hand and was also cross-referenced with an online platform known as "Connected papers" (https://www.connectedpapers.com/) (Behera et al., 2023; Eitan et al., 2020). A graphical depiction from connected papers is shown in **Figure 4** using Petriwskyj et al. (2016).

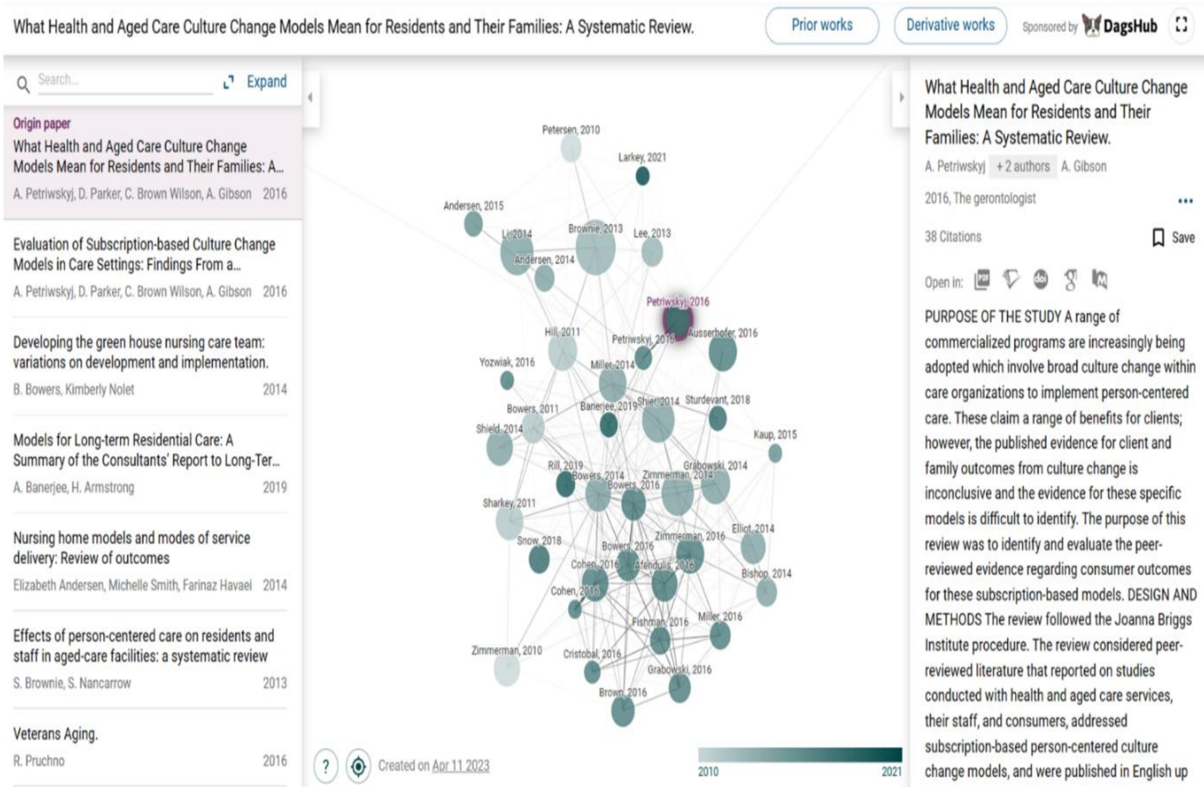


Figure 4 Connected Paper Output

Output

This platform provided the opportunity to place a core paper into a search engine, which then ran an algorithm using the core paper to searches that had referenced it and the influences on the original paper. This was helpful in ensuring that the initial search had been carried out for completeness and to identify other relevant articles that may have been missed, as **Figure 4** illustrates. The response from the databases were very similar in terms of results. Furthermore, the core papers and the reference lists were reviewed for additional sources to inform the broader study and the questions under consideration. As this thesis progressed over several years, the searches were ongoing, with alerts or notifications using key terms established for ready identification.

2.4.7 Grey Literature and Conference Proceedings

Grey literature, conference proceedings and websites were also included in the search for person-centred care model implementation. These included documents from Joseph Rowntree Foundation (https://www.jrf.org.uk/), My Home Life (https://myhomelife.org.uk/), The Pioneer Network, The Green House Project (https://thegreenhouseproject.org/)[2], Eden (https://www.edenalt.org/) Eden in Oz & NZ (https://edeninoznz.com.au/), Action Pact (https://www.actionpact.com/), International Federation on Ageing (https://ifa.ngo/), the Institute for Healthcare Improvement (https://www.ihi.org/) and ISQUA (https://isqua.org/), International Dementia Conference and the International Federation of Ageing and Global Ageing Conferences. It is noteworthy that during the Royal Commission into Aged Care Quality and Safety, several research papers were commissioned and published; these were also included in searches. Collectively, these techniques over the life of the study assisted in ensuring the fullest dataset of literature possible.

Given that I took a first-principles approach to the overall study, I ensured that any inherent bias from my personal experience in leading and delivering change over 20 years was

[2] The Green House project and the Pioneer Network formed an alliance under a parent name the Centre for Innovation (Press release 28/11/2022) https://thegreenhouseproject.org/press-releases/center-for-innovation-announces-combined-leadership-structure. In 2025, this group has further rebranded and changed name to be AgeingIn™ https://aginginnovation.org/

minimised. This initial scan of the available literature was deliberately wide to ensure the search was as comprehensive as possible.

2.4.8 Screening and Review

The literature refinement process incorporated thematic analysis, facilitated through the development of a literature mapping framework. This systematic mapping approach enabled visual representation (see Appendix 9.5) of the relationships between sources and enhanced the identification of conceptual linkages in the literature (Creswell & Creswell, 2017). This graphical method assisted me greatly, given the number of records returned that were associated with the topic and further assisted with a broader first-principles approach to the research. Six major independent themes were identified: person-centred care as a philosophy, culture change models to deliver person-centred care, implementation aspects, reviews and evaluations of the implementation of culture change, a series of individual studies on quality of life and quality of care and, finally, a series of systematic reviews. These findings were reviewed and discussed with my supervisors.

Given the rigour associated with conducting systematic reviews from identification and synthesis and their associated objectivity, these papers were selected as the focus of further detailed review. From both the initial screening and the visual representation of the literature, it was clear that on reviewing each of the systematic reviews that many of the studies within the themes were in fact contained in the systematic reviews. Therefore, the systematic reviews were considered the most important papers with regards to the research questions. Once duplicates were removed using Endnote x9, filtering of the data occurred in a sequential manner, based on English language, peer-reviewed journal and the countries Australia, New Zealand, the UK, the USA, Ireland and Canada.

Articles were screened based on title and abstract, then saved and exported to Excel for further analysis and review. Full-text screening was then done to ensure that the articles were indeed applicable. Systematic and/or scoping reviews were prioritised according to the extent of literature previously considered for business cases in my substantive roles. Also, systematic reviews were deemed the best way to understand the issues and potential gaps in the most comprehensive manner to meet the aims of the study. Systematic reviews by their very nature

(comprehensive methods, explicit criteria and synthesis of multiple studies with a number of reviewers to mitigate bias) provide a wider evidence base than one isolated study or paper (Fetherstonhaugh et al., 2010; Shields, 2010). This was particularly helpful for this study.

As the articles were screened, the steps and rationale were documented. The results for each stage of the refinement process were guided by the PRISMA statement and protocols (Sarkis-Onofre et al., 2021) and were mapped in the PRISMA flow chart (**Figure 5**).

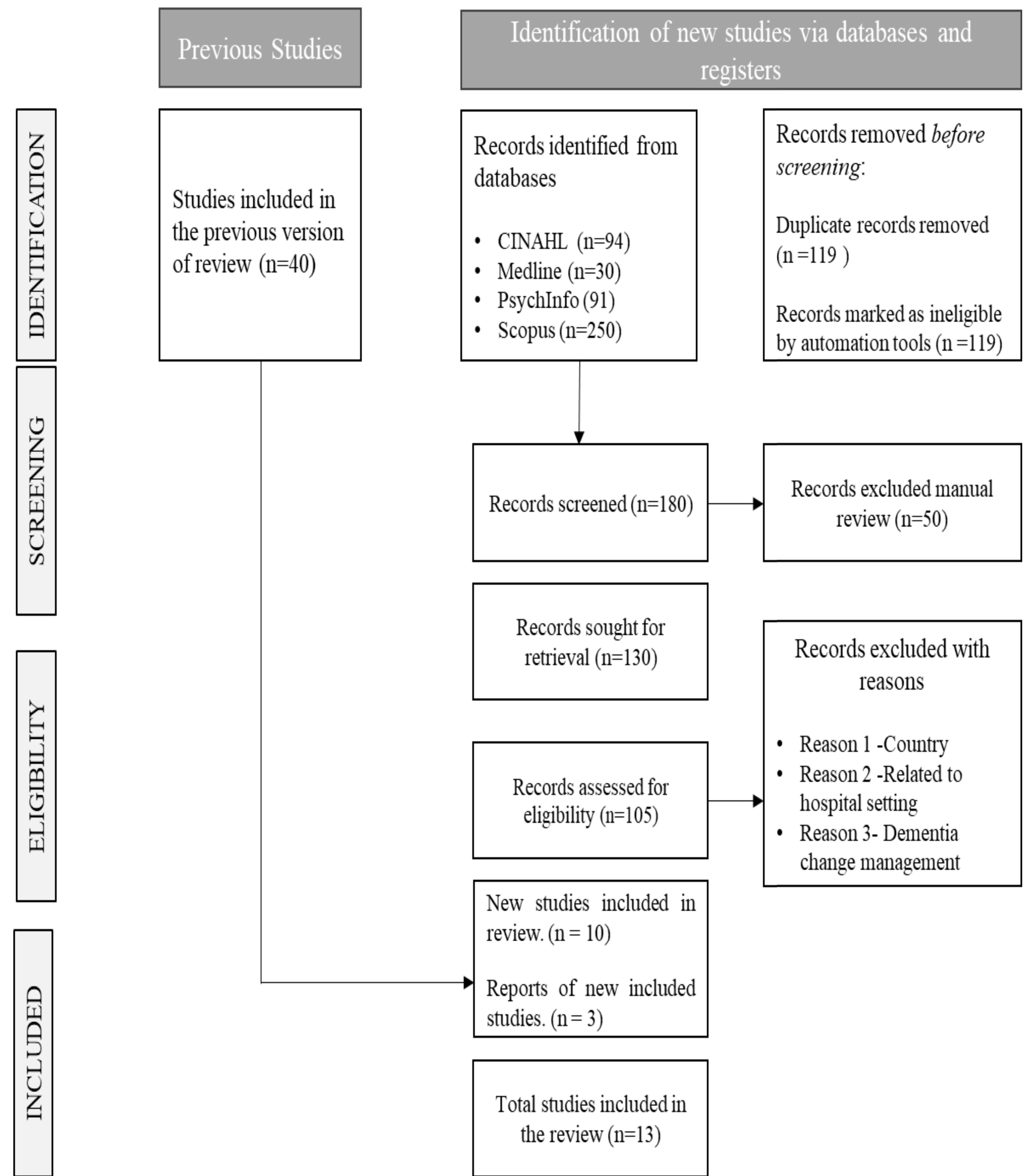


Figure 5 Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Flow Diagram

The search was limited to articles published in English between 2010 and early 2023. The databases yielded 16,139 articles when limited by geography (Australia and New Zealand, UK and Ireland), English language and academic journals. The thirteen (13) articles included in the

final screening accounted for the breadth of the terminology in the literature. There was some debate regarding one paper (Dyer et al., 2019) which had been commissioned for the RCACSQ and had several streams of review on innovative models for aged care. While it could be excluded, the technical reports and reporting enabled the separation of the findings to be included, given the search strategy and sample size. That said, the volume of material was significant and difficult to isolate completely. Importantly, from an Australian perspective, it included models of care for Indigenous people and for these reasons it was included. Conversely, a Canadian report on models to enhance quality for Ontario Long-Term Care, while helpful, included no methodology or search criteria and was therefore excluded (Armstrong et al., 2019).

The purpose of this review was not to evaluate the efficacy of interventions but rather to understand the influences associated with person-centred model implementation. Nor was a meta-analysis undertaken, given the volume and breadth of the studies identified. The results that follow are therefore presented in narrative form with a series of tables to present core aspects associated with the studies identified.

2.4.9 Data Analysis and Synthesis

As noted previously, 13 studies, which included systematic and/ or scoping review papers, were ultimately selected and analysed. The 13 studies covered the extent of the research questions, quality of care, quality of life, evaluation of interventions to support person-centred model implementation and culture as they related to quality care provision and related perceptions.

A series of tables with explanatory content, which present analyses of the reviews and a discussion of the findings as they relate to this study, follows. These tables are

- Table 5 Included Studies – Authors, study title, country, year of publication, study aim/s, study questions and findings of each study
- Table 6 Literature Review – Studies Per Year
- Table 7 Table Literature Review, Studies by Country
- Table 8 Databases Used – Study design, protocols and databases used and papers return
- Table 9 Literature Funding Sources and Affiliations – Analysis of research affiliation and funding sources

- Table 10 Literature Review Key Themes
- Table 11 Person-Centred Definition
- Table 12 Terminology for Older People

Table 5 Included Studies

	Author and Year of Publication / Country/ Title	**Study Aim**	**Findings**
1	Chapin, 2010 / USA *The Language of Change: Finding Words to Define Culture Change in Long-Term Care.*	To examine the definitions of culture change.	There was no agreed definition for culture change in the search. Fourteen (14) different definitions were returned. The author proposed a new definition to support transformation.
2	Hill, et al. 2011 / USA *Culture change models and resident health outcomes in long-term care.*	To examine the scientific evidence for the effect of comprehensive culture change model implementation on resident health outcomes in long-term care.	Evidence regarding long-term care residents' health outcomes after comprehensive culture change model implementation was inconsistent and the grade of the evidence made practice recommendations difficult at this time. However, integrated findings across studies demonstrated potential psychosocial benefits for long-term care residents.
3	Bradshaw, Playford, & Riazi, 2012 / UK *Living well in care homes: a systematic review of qualitative studies.*	To conduct a systematic qualitative review of care home life and provide practical recommendations to enhance residents' quality of life.	People in care homes voiced concerns about lack of autonomy and difficulty in (i) acceptance and adaptation, (ii) connectedness with others, (iii) a homelike environment and (iv) caring practices.
4	Brownie & Nancarrow, 2013 / Australia *Effects of person-centred care on residents and staff in aged care facilities: a systematic review*	To evaluate the evidence for an impact of person-centred interventions on aged care residents and nursing staff.	Person-centred interventions were found to be multifactorial, comprising elements of environmental enhancement; opportunities for social stimulation and interaction; leadership and management changes; staffing models focused on staff empowerment; and assigning residents to the same care staff and an individualised philosophy of care. The complexity of the interventions and range of outcomes examined made it difficult to form

	Author and Year of Publication / Country/ Title	Study Aim	Findings
			accurate conclusions about the impact of person-centred care interventions adopted and implemented in aged care facilities.
5	Shier, et al. 2014 / USA *What Does the Evidence Really Say About Culture Change in Nursing Homes?*	The review used an analytic framework to describe the existing evidence base about culture change in nursing homes by answering four main questions: (a) What are the nature and scope of nursing home culture change interventions that had been studied? (b) How have culture change and the extent of adherence to interventions been measured? (c) How have culture change outcomes been measured? (d) What is the relationship between nursing home culture change interventions and outcomes?	Resident outcomes and family and resident satisfaction and experiences were mixed. The outcomes for these models were at best comparable with traditional care with limited suggestions that they resulted in poorer outcomes and sufficient potential for benefits to warrant further investigation. Although these models may have had the potential to benefit residents, the implementation of person-centred principles may affect the outcomes.
6	Low et al., 2015 Australia *A systematic review of interventions to change staff care practices in order to improve resident outcomes in nursing homes.*	To systematically identify and describe studies that have investigated the effects of interventions: 1. to change staff practice or care approaches in order to improve resident outcomes in nursing homes; 2. to identify interventions or intervention components which lead to successful staff practice or care approach change in nursing homes; 3. to identify potential barriers and enablers to staff practice or care approach change in nursing home.	No single intervention component, combination of, or increased number of components was associated with greater likelihood of positive outcomes. While studies with positive outcomes for residents tended to change staff behaviour, changing staff behaviour did not necessarily improve resident outcomes. Studies targeting specific care tasks were more likely to produce positive outcomes than those requiring global practice changes (e.g., care philosophy). Changing staff practice in nursing homes is possible but complex. Interventionists should consider barriers and feasibility of program components to impact on each intended outcome.
7	Petriwskyj, et al., 2016 / Australia *What Health and Aged Care*	The purpose of this review was to identify and evaluate the peer-reviewed evidence regarding consumer outcomes for subscription-based models person-centred culture change models.	Resident outcomes and family and resident satisfaction and experiences were mixed. The findings suggest potential benefits for some consumer related outcomes, particularly related to quality of life and psychiatric symptoms, staff

	Author and Year of Publication / Country/ Title	Study Aim	Findings
	Culture Change Models Mean for Residents and Their Families: A Systematic Review.		engagement, and functional ability. Although some improvements in residents' lives were identified, both also identified problematic aspects of the change related to staff adjustment and staff time, p. e12
8	Caspar, et al. 2016 / Canada *Practice Change Interventions in Long-Term Care Facilities: What Works and Why?*	Using a modified realist approach, to address what practice change-intervention characteristics work, in what circumstances they work and why.	Interventions that included only predisposing factors, (communication and dissemination of information) were least likely to be effective. Interventions that included reinforcing factors (mechanisms that reinforce new skills and practices, e.g. coaching, hands-on practice, mentoring, supervision, team meetings) were most likely to produce sustained outcomes. The authors concluded that interventions aimed at practice change in LTC settings should include feasible and effective enabling and reinforcing factors, p. 380.
9	Petriwskyj, et al. 2016 / Australia *Evaluation of Subscription-based Culture Change Models in Care Settings: Findings from a Systematic Review.*	To explore how subscription-based person-centred culture change models have been evaluated. The review focused on three questions: 1. What outcomes and indicators have been measured in evaluation? 2. What measures have been used for these outcomes? 3. What are the quality characteristics of the studies?	There was no single model for which a significant body of evidence was identified and approaches to outcomes were fragmented. Research approaches varied. Despite their structured approaches, research and evaluation for subscription-based models were limited, ad hoc and fragmented. A more comprehensive program of research that is embedded in the implementation process is needed. Recommendations include use of longitudinal study designs, attention to implementation and contextual factors and measurement of both process and outcomes across the full range of culture change domains, p.1.
10	Dyer et al, 2019 / Australia *Review of Innovative Models of*	Review of innovative models of care delivery for the whole spectrum of aged care specifically for searched for 1) reviews in residential aged care broadly, 2) reviews for specific populations in aged care, and 3) searches for reports of innovative approaches in specific	Small-scale, domestic models of residential aged care, where there was an emphasis on providing person-centred care that maximised the independence of the residents and participation in routine, domestic activities in a homelike setting for smaller groups of residents met consumer

	Author and Year of Publication / Country/ Title	Study Aim	Findings
	Aged Care.	populations or settings.	preferences better and limited evidence indicated benefits for residents, including reduced restraint use. These models have been successfully implemented in Australia but has limited availability. Perceptions of higher cost may be a barrier; capital costs may be slightly higher but running costs can be no greater and may be less. p. 9.
11	Naidu, 2019/ Australia/ *Leadership and Management Strategies That Promote the Implementation of Consumer Directed Care in Residential Aged Care Facilities.*	The research question focused on the leadership and management strategies used to promote the implementation of consumer-centred care in residential aged care facility.	One major theme that emerged from the analysis was transforming the organisational culture through changing the organisational systems, embracing the “yes culture” and changing the individuals’ work habits. The “yes culture” means that all individuals are dedicated to succeeding in making excellent decisions autonomously. p. 91.
12	Cleland, et al. 2021 Australia *What defines quality of care for older people in aged care? A comprehensive literature review.*	To identify and synthesise international literature relating to the quality of care in aged care.	The review identified nine key themes as salient to the quality-of-care experience, which included 1. treating the older person with respect and dignity; 2. acknowledging and supporting their spiritual, cultural, religious and sexual identity; 3. improving the skills and training of the aged care staff providing care; 4. relationships between the older person and the aged care staff; 5. Informed choices; 6 social relationships and the community; 7. supporting the older person’s health and wellbeing; 8. ensuring the delivery of safe care in a comfortable service environment, and 9. the opportunity and processes to make complaints and provide feedback to the aged care organisation. p. 774.

	Author and Year of Publication / Country/ Title	Study Aim	Findings
13	Churruca et al., 2023 / Australia. An integrative review of research evaluating organisational culture in residential aged care facilities.	The aim of this review was to integrate diverse studies of organisational culture in aged care facilities. The following research questions were: 1. How is organisational culture being studied and conceptualised in RACFs? 2. What are the primary aims and results of studies on organisational culture in RACFs? 3. What interventions are being designed and used to improve organisational culture in RACFs?	The review highlighted the heterogenous nature of this research area, whereby differences in how culture is demarcated, conceptualised and operationalised has likely contributed to mixed findings. Future research needs a clear theoretical framework to underpin future empirical evidence for culture change.

The final selection of papers included 13 reviews that spanned the period from 2010 to 2023. These reviews encompassed original studies conducted between 1995 and 2023. **Table 6** Literature Review – Studies Per Year below depicts the reviews by year of publication. There is a peak in the data, with more studies published between 2015 and 2019.

Table 6 Literature Review – Studies Per Year

Studies per year										
Year	2010	2011	2012	2013	2014	2015	2016	2019	2021	2023
Number	1	1	1	1	1	1	3	2	1	1

Table 7 Table Literature Review, Studies by Country presents the studies included in the scoping review by country of origin, one (1) each from the UK and Canada, three (3) from the USA and seven (7) from Australia. two of the Australian studies were by the same authors, with the same methodology but different questions (Petriwskyj et al., 2016a; Petriwskyj et al., 2016b).

Table 7 Table Literature Review, Studies by Country

Studies by country			
Australia	Canada	UK	USA
7	1	1	3

2.4.10 Methods and Databases Used in the Studies

Table 8 Databases Used provides an overview of the research design, the databases used and the search return from each of the 13 studies. Each of the selected studies used a minimum of four databases and some had as many as 10. The total number of papers reflected in the reviews was more than 200.

Table 8 Databases Used

Author/s and Year of Publication	Research Design	Databases	Search Return
Chapin, 2010/ USA	Systematic Review	Not listed, though the article describes the search strategy to include 150 books, journal articles, professional trade journals newspaper articles, web resources and other resources, such as conferences, resident brochures and training manuals.	14 different studies or sources were included.
Hill, et al, 2011, /USA	Scottish Intercollegiate Guidelines Network (SIGN)	CINAHL, Pubmed.	11 studies.
Bradshaw, Playford, & Riazi, 2012 / UK	Systematic Review	PsycINFO, MEDLINE, Web of Science, EMBASE, Allied and Complementary Medicine Database and Cumulative Index to Nursing and Allied Health Literature.	Included 31 studies.
Brownie & Nancarrow, 2013 / Australia	Systematic Review JBI	MEDLINE, CINAHL, Academic Search Premier, Scopus, ProQuest and Expanded Academic ASAP databases for studies published between January 1995 and October 2012,	Nine (9) articles (7 studies).
Shier, et al, 2014 /USA	Analytical framework	PubMed, CINAHL, PsycINFO, Web of Science and Evidence Based Medicine Reviews and grey literature indexed in Web of Science Conference Proceedings, the New York Academy of Medicine Grey Literature Report and the National Library of Medicine catalogue.	36 studies (31 peer-reviewed articles reporting on 27 distinct studies and 9 grey literature publications) met the inclusion criteria.
Low, et al. 2015 /Australia	Systematic Review	Ovid MEDLINE, PubMED; MEDLINE, Scopus Cochrane Central Register of Controlled Trials, Cochrane Database of Systematic Reviews, CINAHL (Cumulative Index to Nursing and Allied Health Literature), PsycINFO and Database of Abstracts of Reviews of Effects.	63 unique studies
Petriwskyj, et al. 2016/ Australia	Systematic Review JBI	Initially PubMed and CINAHL, then CINAHL; PsycInfo; Web of Science; PubMed; Embase; Sociological Abstracts; Proquest dissertations and theses globally; Proquest research library; Google Scholar and Caresearch. Finally, the reference lists of identified studies were searched for additional articles.	Systematic review of 19 articles reporting findings on 27 studies published between 2002 and 2014.
Caspar, et al. 2016/ Canada	A modified Realist Approach	Two-phase approach (1) academic Search Complete, Ageline, CINAHL, MEDLINE, PsycINFO and Social Science – and (2) undertaking manual searches of journals and reference lists of the retrieved articles.	94 articles met the criteria
Petriwskyj, et al. 2016/ Australia	Systematic Review	10 databases (CINAHL; PsycInfo; Web of Science; PubMed; Embase;	28 articles reporting on 33 studies.

Author/s and Year of Publication	Research Design	Databases	Search Return
	JBI	Sociological Abstracts; Proquest dissertations and theses globally; Proquest research library; Google Scholar and Caresearch).	
Dyer et al., 2019 / Australia	Systematic Review	Multiple databases included in the detailed separate technical report that accompanies the review. MEDLINE, Cochrane and HTA databases.	MEDLINE search: 249 results Cochrane search: 404 results Physical and design changes MEDLINE search, November 2017, modified for Embase, CENTRAL, PyscINFO, CINAHL, hand searches and three trial registries. 11,693 citations, 7751 unique records
Naidu, 2019 Australia	Systematic Review NICE Guidelines	PubMed, MEDLINE and Cochrane, nursing leadership journals from the Griffith University library and Google.	85 studies
Cleland, et al. 2021 / Australia	Comprehensive literature review	Scopus, PubMed.	33 peer-reviewed studies and 5 grey literature sources
Churruca, et al. 2023 / Australia	Systematic Review	Ovid MEDLINE, Scopus, PsycInfo, CINAHL, Embase).	92 articles were included in the 59 studies.

2.4.11 Databases Used by the Studies

A full range of databases associated with health and social care were used for the searches, including CINAHL, PsychInfo, Scopus, Embase, MEDLINE, ProQuest, Web of Science, conference proceedings, dissertations, Google Scholar and hand searches of reference lists and grey literature. The number of studies included exceeded 400. It was difficult to quantify the exact number of studies in the Dyer et al. (2019) paper as it contained innovations across multiple groups. The results were very large and included 7751 unique records.

2.4.12 Methods and Protocols Used by the Studies

From a method viewpoint, several guidelines and their associated protocols were used to evaluate the studies, as shown in **Table 8** above. Three (3) studies used the Joanna Briggs Institute (JBI) guidelines (Moola et al., 2015), one (1) used the Cochrane Effective and

Organisation of Care (EPOC) guidelines, one (1) study used the Scottish Intercollegiate Guidelines Network (SIGN) methodology (Harbour et al., 2011), one (1) used the RAMSES model (Wong et al., 2013) as their method and their associated protocols and methodological tools and 1 used the NICE guidelines for assessing the literature. The Dyer study commenced with several scoping reviews before the published systematic review and all the technical support papers were made available on the Royal Commission into Aged Care Quality and Safety website (Dyer et al., 2019).

2.4.13 Funding Sources and Affiliations

Reviewing funding sources and the associated independence of findings is an important aspect of a literature review (Purssell & McCrae, 2020; Viswanathan et al., 2018). Eleven (11) of the studies above were funded or commissioned by various agencies, **Table 9**. While the authors acknowledged the funding, they stated that the findings and discussion were independent of the funding agency and therefore bias was mitigated.

Table 9 Literature Funding Sources and Affiliations

Author and Year of Publication	Research Design	Affiliation	Funding
Chapin, 2010 / USA	Systematic Review	University of Wisconsin- Milwaukee (UWM)	Supported by a grant from UWM Graduate school and the American Institute of Architects’ Academy of Architecture for Health
Hill et al., 2011 / USA	Scottish Intercollegiate Guidelines Network (SIGN)	John A. Hartford Foundation Building Academic Geriatric Nursing Capacity (BAGNC)	Support from the BAGNC Award Program
Bradshaw, et al., 2012 / UK	Systematic Review	University of London and Institute of Neurology University of London	Supported by a grant from the MS Society of Great Britain and Northern Ireland.

Author and Year of Publication	Research Design	Affiliation	Funding
Brownie & Nancarrow, 2013 / Australia	Systematic Review JBI	Southern Cross University, Lismore, NSW, Australia	Nil funding or conflicts declared
Shier, et al. 2014 / USA	Used an analytical framework	Veteran Affairs Administration	A number of funding sources declared: Office of Disability, Aging and Long-term Care Policy in the Office of the Assistant Secretary for Planning and Evaluation, the US Department of Health and Human Services. Veterans Affairs Administration.
Low, et al 2015 / Australia	Cochrane Effective and Organisation of Care (EPOC) Systematic Review	University of Sydney, Dementia Collaborative Research Centres (UNSW) and (QUT) and Dementia Study Training Centre, University of Wollongong, University of Western Australia Australian National University (ANU)	Dementia Collaborative Research Centres at University of New South Wales, Queensland University of Technology, and Australian National University.
Petriwskyj et al, / 2015/ Australia	Systematic Review JBI	University of Queensland/Blue Care Research and Practice Development Centre	Alzheimer’s Australia Victoria as part of the Aged Care Services Dementia-Friendly Endorsement Project
Caspar, Cooke, Phinney, Ratner 2016 / Canada	A modified Realist Approach using RAMSES and the Precede Proceed Model	Toronto Rehabilitation Institute University	Supported by a Joseph-Armand Bombardier Canada Graduate Scholarship and an Alzheimer Society of Canada Doctoral Award awarded to S. Caspar
Petriwskyj et al. 2016 / Australia	Systematic Review	University of Queensland/Blue Care	Alzheimer’s Australia Victoria as part of the Aged Care

Author and Year of Publication	Research Design	Affiliation	Funding
	JBI	Research and Practice Development Centre	Services Dementia-Friendly Endorsement Project.
Dyer et al., 2019 / Australia	Systematic Review	Cognitive Decline Partnership Centre Flinders University Bolton Clarke Research Institute South Australian Health and Medical Research Institute (SAHMRI). Stand Out Report	Supported by a research grant awarded by the Royal Commission into Aged Care Quality and Safety.
Naidu, 2019 / Australia	Systematic Review NICE Guidelines	Singaporean evaluation panel	Nil reported
Cleland, et al., 2021 / Australia	Comprehensive literature review	Flinders University and Healthy Ageing Research Consortium, Registry of Older South Australians (ROSA), South Australian Health and Medical Research Institute (SAHMRI),	Supported by a research grant awarded by the Royal Commission into Aged Care Quality and Safety and Australian Research Council Linkage Project
Churruca, et al., Australia / 2023	Systematic Review		Supported by a National Health and Medical Research Council Investigator Grant

2.4.14 Findings of Scoping Review

The literature was visually mapped, read a number of times and discussed with my supervision team. Six themes were identified, as noted in section 2.4.8. from the

systematic reviews which were the result of the search. The included reviews uncovered a range of ways in which person-centredness is represented in the literature. The reviews demonstrated that there was limited evidence for the impact on outcomes for enhanced quality of care and life for people in residential aged care with regards to model and practice implementation over the long term. "Change" and "culture change" were broad themes in the literature, including multiple change definitions, change implementation techniques and the efficacy of the person-centred models available. What constituted "quality cultures" for people living in residential care varied in significant ways. Finally, how older people were referred to in the reviewed studies also varied. **Table 10** Literature Review Key Themes provides an overview of these key themes and related studies, each of which are discussed further in section 2.5 below.

Table 10 Literature Review Key Themes

Key aspects	**Studies**
Terminology and definitions	Chapin; Churruca et al.; Naidu.
Model implementation and impact	Hill et al.; Brownie et al.; Shier et al.; Petriwskyj et al.; Casper et al.; Dyer et al.;
Practice specific aspects	Low et al.; Casper et al.;
Enhanced quality of life	Cleland et al.
Leadership and training	Bradshaw et al.; Low et al.; Casper et al.; Naidu, Churruca et al.
Shifting terminology to refer to older people	Chapin, Petriwskyj et al.; Dyer et al.; Low et al.; Cleland et al.
Policy and context	Shier, Petriwskyj et al.; Naidu, Churruca.

2.5 Definitional Perspectives

2.5.1 Inconsistent Definitions of Person-Centred Models of Care

There appeared to be no clear definition regarding person-centred care to support the research in several of these studies and when definitions were provided, they varied significantly. For instance, Dyer and colleagues, (2019) in their report for the Royal Commission, described person-centred care as a philosophy rather than a model of care (Dyer et al., 2019). This differs from Naidu's (2019) study, which defined person-centred

care as “a care approach that delivers holistic and individualised care in which patients are empowered to make their own health decisions” (Naidu, 2019, p. 75). **Table 11** Person-Centred Definition provides an overview of the definitions included in the studies.

Table 11 Person-Centred Definition

Author and Year of Publication / Country	Definition of Person-centred
Chapin, 2010, / USA	Multiple definitions regarding culture change.
Hill, et al. 2011, / USA	“person-centred or resident-centred care, a philosophy at the core the culture change movement”, p. 31.
Bradshaw, Playford & Riazi, 2012 / UK	The study paper refers to a relationship-centred approach to care, p. 438.
Brownie & Nancarrow, 2013 / Australia	The study uses Carl Rogers’ definition of PCC, p. 2.
Shier, et.al 2014 / USA	“The study uses an analytical framework to assess resident-centred homes.”
Low, et al. 2015/ Australia	No definition recorded.
Petriwskyj, et al., 2016 / Australia	No definition recorded. The study states, “The client is central to care policy, care planning and care provision. Such person-centred models of care have influenced practice development … to whole of organisational culture change”. p. 12.
Caspar, et al. 2016/ Canada	No definition recorded.
Petriwskyj, et al., 2016 / Australia	No definition recorded. The study states, “New models have been developed that focus on person-centred care and a broad approach to culture change within a whole organisation or service p.1.”
Dyer et al.; 2019 / Australia	States that PCC is a philosophy p. 3.
Naidu, 2019/ Australia	“… a care approach that delivers holistic and individualised care in which patients are empowered to make their own health decisions.” p. 75.
Cleland, et al., 2021 /Australia	No definition but states that PCC and quality are linked and formed the basis of the review. p. 766.

Author and Year of Publication / Country	Definition of Person-centred
Churruca, et al., 2023 / Australia	Multiple definitions regarding culture. p. 9.

2.5.2 Literature on Culture Change

This scoping review highlighted the heterogeneity with regards to understanding culture change as it relates to person-centred care model implementation. The Churruca et al. (2023) review highlighted many issues, notably, how culture is demarcated, conceptualised and operationalised and the study also recommended that a theoretical framework be included for future studies.

There were attempts to provide a definition associated with the US culture change movement (Chapin, 2010). Hill et al. (2011) stated that “culture change encompasses specific interventions as well as comprehensive plans to change the entire organisation”. Chapin concluded with her own definition as she argues that this could indeed be the reason culture change fails. The definition is indeed very holistic from a change perspective:

> Culture change in long-term care is a longitudinal, systemic, holistic process of transforming a long-term care organization (people, culture, beliefs, actions) and its physical surroundings, from being embedded in a traditional institutional medical model or philosophy to operating as a holistic therapeutic community-based upon resident-centred care and dignified workplace practices. Culture change is a multitude of efforts aimed at transforming the psycho-social, organizational, operational and physical environment in order to enhance quality of care, quality of experience, quality of life and create a viable sustainable business through developing a triadic setting that is simultaneously a healthy, positive, enjoyable workplace, a loving, supportive home and a thriving community that meets resident-identified physical, social, emotional, and spiritual needs as well as facilitating a high quality of life for all individuals involved. (Chapin, 2010, p. 192)

The nine themes from the Cleland systematic review aligned with the Chapin holistic definition for culture change and include, respect and dignity; acknowledging and supporting spiritual, cultural, religious and sexual identity; the skills and training of the

aged care staff providing care; relationships between the older person and the aged care staff; informed choices; social relationships and the community; supporting the older person's health and wellbeing; ensuring the delivery of safe care in a comfortable service environment, and the ability to make complaints and provide feedback to the aged care organisation (Cleland et al., 2021).

Dyer et al. in their commissioned review (Dyer et al., 2019, p. 2). stated that innovative models (noted in the opening of this chapter) were not routinely used in Australia and defined them as "complex interventions that impact on a person's whole care environment or models of care rather than single modality therapies or therapies targeted at a single aspect of care (e.g., interventions targeted specifically at behaviour)" This is an interesting statement when the converse is stated in other studies, that these models *are* being implemented in Australia (Brownie & Nancarrow, 2013; Petriwskyj et al., 2016b).

2.5.3 Literature on the Implementation of Person-Centred Models

A number of the studies demonstrated that the implementation of culture change was inconsistent (Hill et al., 2011; Shier et al., 2014) and of limited value in enhancing the quality of care and life for older people (Low et al., 2015; Petriwskyj et al., 2016a; Petriwskyj, Parker, et al., 2015; Shier et al., 2014). Both Shier et al. (2014) and Petriwskyj et al. (2016b) were even more critical, claiming that the implementation of newer PCC models was of no better value than traditional models of care.

A number of issues associated with impacting implementation were highlighted, with staff-related aspects, such as staff turnover, staff workloads and implementation costs cited by a number of the authors (Caspar et al., 2016; Low et al., 2015).

Casper et al. (2016) stated in their conclusion that predisposing factors (communication and dissemination of information) were limited but that reinforcing factors were least likely to be effective. Interventions that included reinforcing factors (mechanisms that reinforce new skills and practices, e.g., coaching, hands on practice, mentoring, supervision, team meetings) were deemed more successful; exploring this further revealed when they were referring to external factors, they were referring to regulators and legislative aspects as factors that inhibited change. They also made an interesting

point about tensions associated with competing or conflicting goals in aged care provision and PCC implementation:

> Incentives in (Long- term care) LTC facilities were often linked to competing or conflicting goals, such as performance-based outcomes that placed more emphasis on regulatory compliance than on residents' individualised needs. Unless reinforcing factors such as motivation, recognition, and incentives are part of an intervention, the day-to-day care practices and routines may be in direct conflict with the successful implementation of an intervention (Caspar et al., 2016, p. 380).

All the studies appeared to conclude that to achieve enhanced person-centred care, interventions need to be multifactorial (Brownie & Nancarrow, 2013), requiring a variety of approaches, which underscores the Chapin definition and the need for more study regarding implementation. Low et al. (2015) and Shier et al. (2014) criticised the lack of a theory of change or underpinning theoretical framework to support the study designs as an issue with regards to evaluating success. Despite these findings, all the studies concluded that more research was needed. Indeed, the components used to quantify success, while important in the experiential care delivery, appeared tactical and associated with an individual aspect of the care process, such as bathing, dining, homelike environments and close relationships with family, staff and community.

2.5.4 Practice and Environmental Aspects with Regards To PCC Model Implementation

Both Bradshaw et al., (2012) and Low et al., (2015) postulated that focusing on specific practice areas appeared to demonstrate more positive outcomes than focusing on staff behaviours and a care philosophy.

Environmental factors such as small-scale domestic models and being homelike in design were seen to maximise independence with routine domestic activities and were more suited to peoples' preferences (Bradshaw et al., 2012; Brownie & Nancarrow, 2013; Dyer et al., 2019). This was also identified by enhanced quality of life, that is, psychosocial benefits were identified in the Hill et al., (2011) study. Skills and training, in particular leadership development, were seen as contributing to culture change (Brownie & Nancarrow, 2013; Low et al., 2015; Naidu, 2019).

2.5.5 Shifting Terminology to Refer to Older People in this Literature

Several terms were used to describe “people”, including “consumer”, “resident”, “person” and “recipient”. Indeed, Naidu explicitly states that “consumer-centred care focuses on health and illness of the patient as well as their family by enhancing confidence, creating awareness and providing support and reassurance” (Naidu, 2019, p. 75).

Across the 13 systematic reviews, the term “consumer” was mentioned in one study in the USA (Chapin, 2010) to refer to older people in residential aged care, but in the Australian studies from 2015, the term “consumer” was used interchangeably with the terms “resident” and “person”. While, prior to 2015 “consumer” is mentioned, it is only in one study, (Chapin, 2010). Rather, from 2015, “consumer” became a common term, particularly in the Australian-authored studies, whereas the other studies used the more common terms of “resident” and “person” with the associated person-centred terms. Further analysis was conducted to determine the frequency of each term used in the selected studies to refer to people, **Table 12** Terminology for Older People depicts these results. Despite seeking to understand why these changes occurred, there was limited-to-no explanation for these choices.

Table 12 Terminology for Older People

Author and Year of Publication / Country	**Terms in Use**				
	“Consumer”	**“Customer”**	**“Resident”**	**“Recipient”**	**“Person”**
Chapin, 2010, / USA	1	0	28	0	20
Hill, et al. 2011, / USA	0	0	87	0	1
Bradshaw, Playford, & Riazi, 2012 / UK	0	0	142	0	22

Author and Year of Publication / Country	Terms in Use				
Brownie & Nancarrow, 2013 / Australia	0	0	12	0	100
Shier, et al. 2014 / USA	0	0	87	0	1
Low, et al. 2015 / Australia	1	0	237	0	28
Petriwskyj, et al. 2015 / Australia	18	0	23	0	20
Caspar, et al. 2016 / Canada	0	0	38	0	15
Petriwskyj, et al. 2016 / Australia	2	0	72	2	19
Dyer et al, 2019 / Australia	16	0	12	0	100
Naidu, 2019 / Australia	80	0	47	0	20
Cleland, et al. 2021 / Australia	49	0	199	0	77
Churruca, et al 2023 / Australia	0	0	9	0	18

2.5.6 Policy and Context in this Literature

Despite aged care being legislated as part of the health departments in most countries, it was surprising to find minimal reference in the various studies to aged care policy. In their analytical framework, Shier et al. (2014) were the most explicit

in accounting for policy and the legislative pillars as a consideration when organisations were implementing person-centred care models. There were cursory references to policy in the introductions to a number of studies (Churruca, Falkland, et al., 2023; Dyer et al., 2019; Naidu, 2019). The Naidu (2019) study contained and referenced policy shifts in the interventions implemented. Petriwskyj et al. (2016) concluded that implementation of person-centred culture change needed to consider organisational enablers in a dynamic developing market to achieve culture change, which could have been a reference to policy changes. However, it is interesting that the term "market" was used to refer to a human services sector, which may have indicated a larger shift in the policy settings which this term was referencing.

2.5.7 Section Conclusion

The findings of this scoping review prompt two questions that warrant further examination. First, was this shifting terminology in policy an area that affected the implementation of person-centred care models? Second, what events or developments occurred in Australia before and after 2015 that might have led to the interchangeability of terminology when referring to older people?

2.5.8 Strengths and Limitations of the Scoping Review

This scoping review of systematic reviews enabled a high-level understanding of the literature on the implementation of person-centred care models. It identified that in more than 400 articles, little if any attention has been given to the government policy dynamics surrounding such implementation. It further underscored the inconsistent definitions of person-centredness. The systematic review itself revealed an overlap in the systematic reviews of papers included in the studies, indicating the rigorous nature of the approach taken and search terms used. Given the time from research to publication and how I operationalised inclusion criteria, I recognise that not all relevant studies may have been included.

A significant limitation of any investigation of quality of life and quality of care is the subjective nature of the term "quality" and perceptions of what this relates to. Every effort has been made to mitigate and determine an objective and comprehensive understanding of quality, which can be applied to and underpin this

study. To mitigate this further, the systematic reviews were discussed and reviewed with the supervision panel.

2.6 Conclusion

Drawing on the contextual overview and the systematic reviews included, this literature review reinforces earlier findings that, despite continued research, significant gaps remain in understanding how person-centred care is conceptualised and in how to create, implement and maintain person-centred cultures.

The review also highlighted a notable finding about the changing language and terminology used to refer to older people, particularly in the Australian studies, namely, the shift to the term "consumer". These shifts in terminology may have important implications for how care is understood and delivered. The following chapter provides essential contextual background on Australian aged care policy developments to enhance quality of life and quality of care for older Australians in residential aged care. It will also provide insight into the local legislative and regulatory landscape.

3. Australian Regulatory Context and Reviews

3.1 Introduction

"Those who cannot remember the past are condemned to repeat it."
George Santayana, 1905

Chapter 2 reviewed the literature regarding quality of care and quality of life for people living in residential aged care, including the various models and approaches available to enhance residents' lived experience of residential aged care settings. It also highlighted the shifting terminology in the Australian-authored literature used to describe people receiving care.

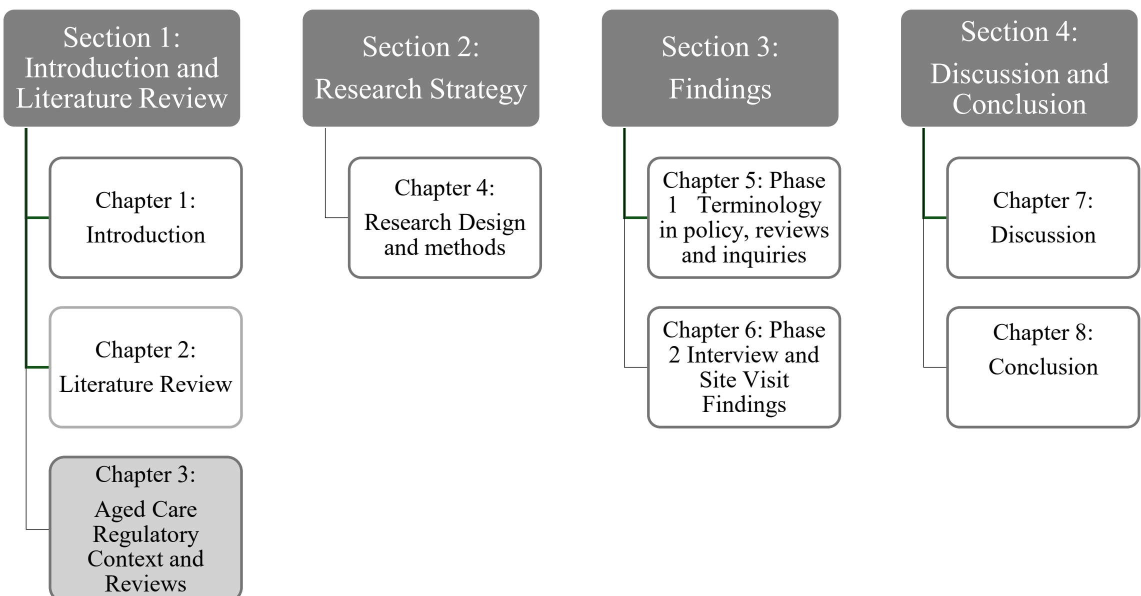


Figure 6 Thesis Outline Chapter 3

This chapter, the last in this introductory section, provides a contextual overview of the Australian aged care system, of which residential aged care is a key part. It describes how the legislative system seeks to protect and ensure the quality of life and care for people in residential aged care through the legislative pillars of regulation, funding and provider approval processes. It evidences how language in the legislative system has shifted to enhance the notion of quality care and quality of life for people living in residential aged care. It also provides an overview of the processes regarding government-initiated reviews and reports to ensure the effectiveness, quality and sustainability of the aged care

system over the decade from 2011 to 2021. The focus of this study is residential aged care, the largest part of the Australian aged care system. However, policy reviews generally review all aspects of the aged care system, and this has been considered and contextualised throughout the study.

3.2 Contextual Overview of Ageing and Aged Care in Australia

At the time of writing, the Australian aged care sector was undergoing unprecedented legislative and policy changes following publication of *Care, Dignity and Respect*, the final report of the Royal Commission into Aged Care Quality and Safety 2021. A new aged care bill, was passed by the Australian Government on 25 November 2024, becoming the *Aged Care Act 2024,* introducing a series of transformative changes aimed at improving the quality of care and quality of life for older Australians. This once-in-a-generation legislation was initially set to take effect from 1 July 2025 but was delayed to 1 November 2025. This new Act responds to 58 of the 148 recommendations from the RCACQS and embodies a fundamental shift towards a more person-centred approach. Aimed to make Australia's aged care system stronger, the Act also introduces:

- a Statement of Rights for older people,
- Strengthened Aged Care Quality Standards, that outline what quality and safe aged care services are,
- a new regulatory framework, and
- stronger powers for the regulator, the Aged Care Quality and Safety Commission.

(Wells et al., 2019, p. 1) have stated that "policy and cultural contexts in which aged care operates vary significantly across nations, even those with comparable systems of healthcare". Therefore, this opening section will provide a contextual overview of the number of older Australians and then outline how Australian aged care is administered and regulated.

3.2.1 Population Ageing

Like most OECD countries, the Australian population is ageing (Commonwealth of Australia, 2015). While this increase in longevity is to be celebrated, it is associated with increasing need for formal and informal care services (Australian Institute of Health and

Welfare (AIHW), 2022). There are several types of support available to assist older Australians. In their own homes, older people can access domestic assistance and personal care through community care packages, which may also include clinical care. These packages are designed to enable individuals to remain at home while receiving the necessary support. When care and clinical needs exceed what can be managed at home, older Australians may move into residential aged care facilities, where they can receive higher levels of medical and personal care.

3.2.2 Aged Care Provider Characteristics

There are more than 1.3 million people in Australia receiving a variety of aged care services, ranging, as described above, from domestic assistance in their own homes to services provided in residential aged care, where 220,000 people are living (Australian Institute of Health and Welfare (AIHW), 2023). The sector has 811 approved providers, who operate with 2,671 services, providing 219,965 operational places (Australian Institute of Health and Welfare (AIHW), 2023; Sutton et al., 2023). The service providers fall into three main categories:

1. not-for-profits (NFPs) or for-purpose organisations
2. private providers (for-profit), and
3. listed providers, i.e., listed on the stock exchange.

Australian aged care service providers are largely operated by the NFP (religious, charitable and community), state government or private (for-profit)[3] organisations, one of which is listed on the stock exchange. The NFPs operate 57% of the services (Australian Institute of Health and Welfare (AIHW), 2023). The aged care sector is a key portfolio within the Federal Government's Department of Health and Aged Care, charged with funding and regulating this large and disparate sector. This is important to this study, as the policy and regulatory frameworks that manage and control Australian aged care are centrally designed. Consequently, this underpins the aim of this study, which is to

[3] At the outset of the study, four (4) aged care providers were listed on the Australian Stock exchange. At the time of writing, this had decreased to one (1), Regis Aged Care.

examine how language and terminology used in government policy influence the implementation of person-centred care models in residential aged care.

3.2.3 Governmental Oversight and Administration

The aged care sector represents a substantial component of Australia's health and social care economy, with operations supported by more than $26.6 billion in annual government spending (Australian Institute of Health and Welfare (AIHW), 2022; Sutton et al., 2022). The sector in Australia is similar to that in other comparable countries with regards to its legislative oversight and governance (Eyers et al., 2024). The sector is governed by an Act of the Australian Parliament and overseen by the Department of Health and Aged Care (DOHAC).

As of May 2025, DOHAC was one of the largest government portfolios, led by the Minister for Health and Ageing, The Honourable Mark Butler, a senior minister who sits in cabinet. This minister is supported by four additional ministers for health-related portfolios. Two of these four Ministers support Minister Bulter specifically, for Aged Care, these are, the Minister for Aged Care and Seniors and an Assistant Minister for Health and Aged Care, both of which sit in the outer cabinet. To understand the aged care sector more comprehensively, the next section will explore its legislative foundations.

3.3 Legislative Underpinnings

To understand Australian aged care as it is today, it is important to trace a brief history of the legislative underpinnings that have shaped it. The socio-cultural underpinnings are important and pertinent to this thesis as Australian aged care has experienced an interesting growth trajectory both in terms of shape, size and legislation. Successive governments have had to respond initially to the welfare aspects of older Australians and subsequently an ageing population, that is "baby boomers", and in the wake of the Second World War, an increasing number of migrants. In Australia, the provision of aged care services, incorporating services from domestic assistance in their own homes to services provided in residential aged care, has been the responsibility of the Federal Government since the 1950s and has had two Acts, which have legislated service delivery over 70 years of operation (Cullen, 2003). These are the *Aged Persons' Homes Act 1954* (Cth) and *The Aged Care Act 1997* (Cth). Acts contain rules and principles as subordinate

legislation. Most legislation gives the accountable minister discretionary powers to exercise certain, limited, decisions pertaining to different parts of the relevant Act, for instance, to extend exemptions or take into account special circumstances and amend the subordinate legislation as required under other relevant legislation and rules associated with federal business (S. Prasser, personal communication August, 15, 2024). For example, in 2018, the Minister for Aged Care and Indigenous Health exercised these powers to establish mandatory quality indicator collection and reporting for all residential aged care providers. This National Aged Care Mandatory Quality Indicator Program was administratively implemented through the principles or rules within the Act. Other key acts that were relevant to the period of this study and the provision of quality of care are the *Australian Aged Care Quality Agency Act 2013* (Cth) and the *Aged Care Quality and Safety Commission Act 2018* (Cth). These additional Acts govern the regulatory processes of the Australian aged care sector and are discussed section 3.4 of this chapter as they relate to the regulatory processes.

A comprehensive understanding of the current policy settings necessitates a brief examination of the Australian aged care context, along with the policy antecedents that mirror the social and economic landscape of the time.

3.3.1 Aged Persons Homes Act 1954 **(Cth*)***

The *Aged Persons Homes Act, 1954* (Cth) recognised that quality of life was enhanced when people lived in more domestic versus institutional type accommodation settings (Rahn et al., 2016; Robertson, 1974; Woods & Gilchrist, 2020). This challenged the prevailing institutional nature of earlier models where asylums and charitable institutions provided care for indigent people based on a welfare model (Cullen, 2003; Henderson & Willis, 2019; Kendig & Duckett, 2001; Robertson, 2019).

In support of the Act, the Federal Government offered capital grants to counter the institutionalised or asylum-based nature of care provision. These grants and incentives were largely acquired by local communities and faith-based providers or NFPs that matched the grant with local fund-raising initiatives and built aged care homes within their communities to support people who could no longer live independently and care for themselves (Cullen, 2003; Goodwin & Phillips, 2015; Smith, 2019).

There were further revisions and amendments to the *Aged Persons Homes Act 1954* (Cth) reflecting issues within the wider health economy, associated with increased length of stay for people in state-funded hospitals who were long-term patients with chronic diseases and disability. These amendments saw the creation of nursing homes (Cullen, 2003; Goodwin & Phillips, 2015; Henderson & Willis, 2019). Consequently, there were two types of accommodation in operation: nursing homes for older Australians with more complex needs, operating on a medical model, and hostels for people who needed more generalised social and health support, operating on a social model of care.

As the 20th century progressed, successive Australian governments expanded their role in this area and “became increasingly engaged in funding, planning and regulating services for older people” (Cullen, 2003, p. 2). In the late 1970s and early 1980s, a series of failures and reviews led to the admission that the aged care system was financially inefficient with poor-quality care (Gibson, 1998; Venturato et al., 2007). With a change in government in 1996, one of the first major policy changes was to develop a new Act and new approach to aged care provision.

3.3.2 The Aged Care Act 1997 **(Cth)**

In 1996, a new Liberal government was concerned with the increasing cost of the provision of care for ageing adults, and the increase in the ageing population (Henderson & Willis, 2019; Woods & Corderoy, 2021). This concern informed the Budget process of that year and foreshadowed a new aged care Act that has governed Australian aged care for almost 30 years. The Act has been criticised for laying the foundations for a provider-centric, marketised aged care system (Brennan et al., 2012; Duckett & Stobart, 2021) that reduced regulation (Braithwaite et al., 2007) and silenced nursing discourse due to the increased involvement of Assistants in Nursing (AIN’s) / person care workers (PCW’s) overseen by a reduced number of qualified nurses (Angus & Nay, 2003; Braithwaite et al., 2007). The *Aged Care Act 1997* (Cth) is today the overarching legislation covering government-funded aged care. It sets out rules for the core functions of the sector, such as funding, regulation, approval of providers, quality of care and the rights of people receiving care.

A series of principles that sit under the *Aged Care Act 1997* (Cth) provide more detail on these rules and how they interface with other legislative obligations. These principles have been amended over the ensuing years by the minister of the day, when such amendments have been deemed necessary and permitted under the Act. There are 16 sets of principles that reflect the core functions above, for example, quality-of-care principles and user rights principles. The legislative framework interacts with several other healthcare and consumer obligations and, in particular, with building codes. A requirement of the Act is to produce an annual report on its operation and application (Department of Health and Aged Care, 2023).

3.3.3 Amendments to the Act

In 2007, after three terms in government, the coalition Liberal government was succeeded by a Labor government, which had received a mandate for change across all portfolios. The approach the new government took was to commission a series of far-reaching reviews into all government portfolios, including health. Following The *Caring for Older Australians report*, (Productivity Commission, 2011), the Labor Party, led by Prime Minister Julia Gillard, implemented the *Living Longer Living Better Act 2013* (Cth) that amended the *Aged Care Act 1997* (Cth) and introduced significant reforms. The reforms proposed over the ensuing 10-year plan were in four key areas:

- reforms that focus on end-to-end aged care,
- reforms that provide greater choice and control for consumers,
- reforms that provide more sustainable and modernised financing arrangements, and
- reforms that ensure independent advice and oversight to support the changes.

Minister Butler undertook extensive consultation regarding these changes with older Australians and aged care groups, referenced in his speech to parliament as part of the amendments passage through to enactment (Butler, 2013, 2015). Furthermore, and relevant to this thesis, these reforms introduced the term “consumer”, and the policy of consumer-directed-care (CDC), predicated on enhanced choice and control within a market-based system (Henderson & Willis, 2019; Wise et al., 2021; Woods & Corderoy, 2021).

The focus of these reforms was initially on community care provision, though the move to residential care was implicit and contained in subclause (2) (C) of the Act (O'Keeffe & Belardi, 2015; Woods, 2023). These changes have been criticised for introducing further market-based principles, especially purchasing additional services such as wine with dinner, and higher quality rooms (Woods & Gilchrist, 2020).

The amendment to the Act also changed the regulator and regulation processes and implemented consumer outcomes within the new regulatory standards to underscore the shift in direction, by listing "consumer outcomes" in each of the regulatory standards (Wise et al., 2021) (see section 3.4.1).

A further amendment to the *Aged Care Act 1997* (Cth) was the *Quality of Care Principles 2014*, (Cth) which outlined aspects pertaining to quality provision, additional services and additional fees as required, based on the *Living Longer Living Better (LLLB)* reforms. Interestingly, section 11 (1) of the Act states:

> *The Accreditation Standards are intended to provide a structured approach to the management of quality and represent clear statements of expected performance.* ***They do not provide an instruction or recipe for satisfying expectations but, rather, opportunities to pursue quality in ways that best suit the characteristics of each individual residential care service and the needs of its care recipients.*** *It is not expected that all residential care services should respond to a standard in the same way. (Quality of Care Principles 2014, p. 5, bolding added)*

3.4 Additional Legislation and Processes that Underpin Australian Aged Care

The *Aged Care Act 1997* (Cth) is the overarching legislative framework. The Act, determines who can provide care and their roles and responsibilities, who can receive care and their rights and responsibilities, the type of care services available and how aged care is funded (*Aged Care Act 1997* (Cth). The Act is supported by other associated legislation pertaining to the quality-of-care principles and rules contained within it. The associated legislation, which underpins the statutory agency responsible for regulatory framework, the *Australian Aged Care Quality Agency Act 2013* (Cth), and, subsequently, the *Aged Care Quality and Safety Commission Act 2018* (Cth), have been amended over

the decade in terms of scope and remit. Together, they provide the regulatory framework for Australian funded aged care providers.

3.4.1 Australian Aged Care Quality Agency Act 2013 (Cth)

The *Australian Aged Care Quality Agency Act 2013* (Cth) was part of a suite of legislative changes following the *Living Longer Living Better* reforms. It established the Australian Aged Care Quality Agency, which replaced the Aged Care Standards and Accreditation Agency, and outlined the scope of delegations, functions and powers for the agency, including the term and conditions for the CEO.

3.4.2 Aged Care Quality and Safety Commission Act 2018 (Cth)

Following a major scandal in South Australia, the Oakden Inquiry 2017, and a review of the regulatory processes (chapters 3 and 5.5), a further legislative change resulted in the A*ged Care Quality and Safety Commission Act 2018* (Cth*)* which superseded the *Australian Aged Care Quality Agency Act 2013* (Cth) and enabled the establishment of the Aged Care Quality and Safety Commission (The Commission) as the national aged care regulator. The Commission is required to operate and fulfil its functions objectively and independently as per the *Aged Care Quality and Safety Commission Act 2018* (Cth*)* and the associated *Aged Care Quality and Safety Commission Rules 2018.*

The Commission's roles as the national regulator of Australian aged care include:

> (a) the function of protecting and enhancing the safety, health, well-being and quality of life of aged care consumers;
>
> (aa) the function of approving providers of aged care;
>
> (ab) the functions of imposing sanctions on approved providers and lifting sanctions;
>
> (ac) the function of ensuring compliance with the aged care responsibilities of approved providers and provisions of this Act and the Aged Care Act;
>
> (b) the function of promoting the provision of quality care and services by approved providers of aged care services and service providers of Commonwealth-funded aged care services;
>
> (c) consumer engagement functions;

(d) complaints functions;

(da) code functions;

(e) regulatory functions;

(f) education functions;

(g) the function of reconsidering and reviewing certain decisions made under this Act. (Commonwealth of Australia, 2018).

The Commission also manages a number of mandatory reporting aspects associated with the sector, such as the mandatory reporting of various indicators for quality, the Serious Incident Response Scheme (SIRS) and the recently implemented sector-wide star-rating scheme.

Administrative structure

Operationally, DOHAC and the Commissioner collectively administer the Australian aged care system (including residential aged care, home care and community support programs). While independent, the Commission has delegated responsibility for all aspects of the regulatory framework, that is, fiduciary and regulatory. Because of the Oakden failure (see section 3.9.2) and the ensuing Royal Commission, these administrative structures have been in a state of flux due to a multiplicity of capability reviews and recommendations. Following criticism from the RCACQS regarding the similarity of recommendations and the limited implementation of these recommendations despite the multiplicity of reviews, (Royal Commission into Aged Care Quality and Safety, 2019a), a further administrative body was recommended (recommendation 12) (Royal Commission into Aged Care Quality and Safety, 2021). An additional administrative body, the Office of the Inspector-General of Aged Care, was established on the 16 October 2023, to monitor and report on the implementations of the recommendations from the Royal Commission, and to provide systemic oversight of the aged care system. A permanent Inspector-General of Aged Care, Natalie Siegal-Brown was appointed in January 2025, following Ian Yates, who acted as the Interim Inspector-General from 2023.

3.5 Aged Care Funding Models

Australian aged care is part of the Australian universal health care economy. Older people are eligible to have their care costs supported when they enter residential aged care and funded based on an assessment of care needs. Funding assessment tools, as with other legislative aspects, have also been an area that has changed over the duration of this study, in terms of policy and administration. Two funding models were in operation over the duration of this study. Both were classified as "activity-based funding" models, albeit administered differently. The Aged Care Funding Instrument (ACFI) was the initial funding model in place while the empirical work for this study was undertaken. This model was then superseded by the Australian National Aged Care Classification (AN-ACC). This new model had been piloted across a selected number of providers through 2021 and was enshrined in the *Aged Care and Other Legislative Amendment* (*Royal Commission Response Act 2022* (Cth). The primary differences between these models were that the ACFI was managed at the provider level and audited by delegates of the Department of Health or the Commission while the AN-ACC is now assessed independently by an external assessor using standardised assessment tools for both clinical review and associated documentation held at the provider's site. The assessments can be reviewed if a resident is perceived to have had a significant change in their clinical condition and funding varied to reflect staff requirements to support that resident. All funding models are audited by the Commission. The funding "price" is administered by a separate agency, the Independent Health and Aged Care Pricing Authority (IHACPA), whose role is to analyse costs and make pricing recommendations to the Department of Health, Disability and Ageing.

3.6 Section Conclusion

This section provides a contextual overview of Australian aged care policy and the multiplicity of legislative changes that have shaped the aged care sector over the last 50 years. What has been demonstrated is that since its inception, the aged care sector has undergone continuous reforms to address twin challenges, growing demand from an ageing population and government fiscal constraints (Woods & Corderoy, 2021). While focusing on these twin challenges, governments have sought to introduce for older Australians legislation that increases their choices with regards to *how* they age, thereby providing greater control (Woods, 2023). Furthermore, these changes have introduced new language and nomenclature with regards to how people are referred to in the various legislative documents, such as changing "care recipients" to "consumer" and where people reside from "nursing homes" to "residential aged care facilities", as depicted in **Figure 7** Terms for Older People

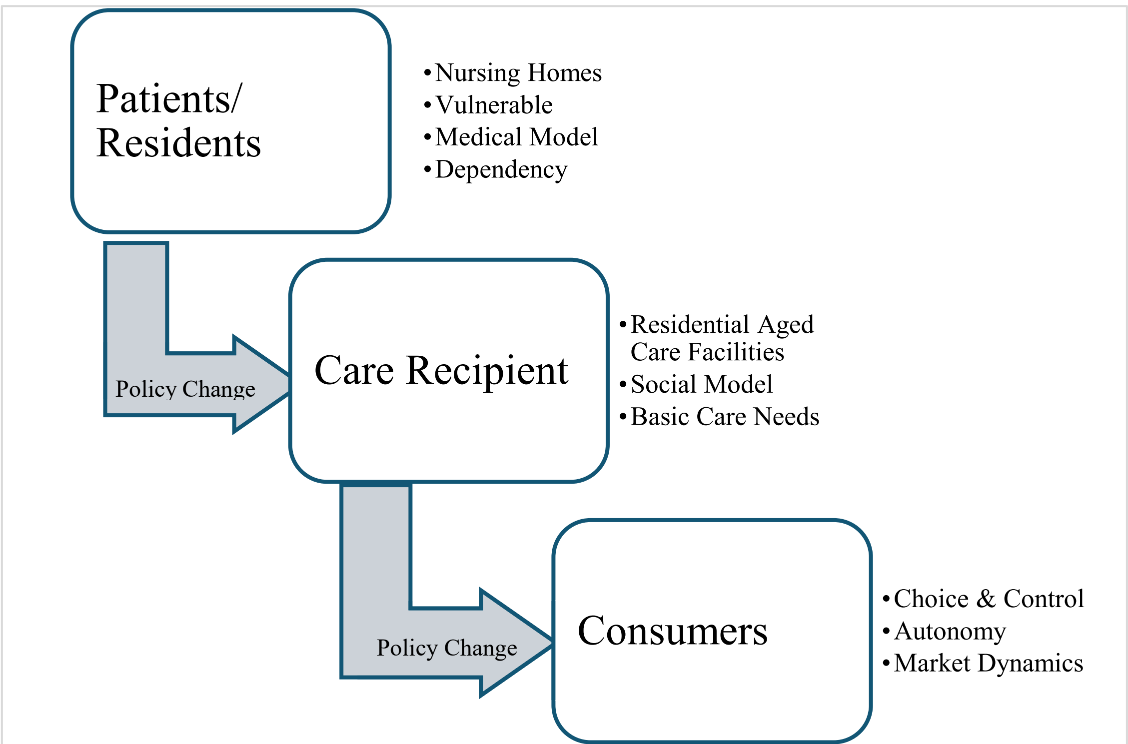


Figure 7 Terms for Older People

These reforms have led the various governments to commission and conduct several reviews to inform policy and financing decisions. As outlined in the opening of this section above, a new aged care Act will come into effect in November 2025 and will

supersede all the legislation that has been outlined above. An overview of how reports and reviews are commissioned within Australian legislative processes now follows.

3.7 Overview of Reviews and Reports

The aged care system in Australia was reviewed on a regular basis over the decade 2011-2021 (Farr-Wharton et al., 2021; Phillips et al., 2018; Royal Commission into Aged Care Quality and Safety, 2019a). Reviews are not in and of themselves a negative aspect of government; indeed, it can be argued that it is essential to review policy settings and none more so than with aged care sector, which has faced sustained and continuing challenges with regards to demographic, social, economic and regulatory pressures almost since its inception. This is not a new phenomenon; rather, it is a perpetuation of what we have seen throughout history with regards to older and/or disadvantaged people (Davidson, 2011). Indeed, reviews are a part of democratic governments worldwide as temporary and ad hoc advisory bodies appointed at the discretion of executive government (Regan, 2017) and as the government of the day responds to externalities and events that have fiscal implications. Some of these reviews are what are known as "legislated reviews", where a review is mandated in new legislation. For example, the *Living Longer Living Better Act 2013* (Cth), mandated a legislative review within five years of the Act becoming law. This legislative review was commissioned with David Tune AO PSM, an experienced public servant and previous Secretary of the Australian Department of Finance, appointed to conduct the review. This legislative review reported to the Honourable Ken Wyatt, Minister for Aged Care and Seniors in 2017.

3.8 The Functions of Reviews and Inquiries

While there is much debate about the core role of government, simply put, it is stewarding complex systems and resources towards purpose and outcomes for its citizens (O'Flynn & Sturgess, 2019). To achieve this, the government of the day has the power to amend, change or develop policy, and, following debate, have these amendments ratified in the House of Representatives and then be scrutinised further in the Senate.

To inform policy decisions, ministers and departments can commission research or a review to assist with policy development. Within the two tiers of Australian government, the House of Representatives and the Senate, predicated on the Westminster system, there

are opportunities to scrutinise issues, bills or policy within the purview of governing and, more formally, by the committee structures accorded with each layer (Banks, 2014). These committees have strict operating procedures with regards to formation, membership and reporting. They also have considerable powers to keep the government of the day in check, with the power to access documents and people to investigate and question government administration and service delivery stakeholders as they deliberate. These committees also oversee public expenditure and may call the government to account for administrative or policy decisions pertaining to their scope. Committee proceedings are recorded in Hansard, and reports and proceedings are available for review (Australian Government Department of Health and Aged Care). Should either chamber have concerns regarding issues or policy, it is within their constitutional remit to commission or call reviews and inquiries (Head & Crowley, 2015).

Finally, formal reviews can be commissioned within the remit of legislation by the minister, i.e., commissions of inquiry which are forensic in nature, particularly those investigating critical issues of public concern. One example is the *Review of National Aged Care Regulatory Processes 2017* (Carnell & Paterson, 2017), which was associated with aged care quality failings, and which is discussed in the next section (Carnell & Paterson, 2017). Equally, reviews can be commissioned to review complex economic or productivity issues, such as *Caring for Older Australian Report* (Prasser, 1985; Prasser & Tracey, 2014). Within the Australian system, these inquiries are governed by various acts, for example, the *Royal Commission Act (1902)* or the *Productivity Act (1998)*. In the case of Royal Commission's, the inquiry is commissioned by the Governor-General at the request of the Prime Minister. Both types of inquiries are conducted on receipt of terms of reference and at arm's length from government so that they can inform policy in the longer term (Prasser & Tracey, 2014; Regan, 2023). They are public, transparent and independent and have powers to summon witnesses, receive submissions and commission their own research. (Banks, 2014) They have set terms of reference which outline the areas for investigation and a timeline for reporting. They are expensive but they do generate considerable evidence. Due to the federated nature of Australia, royal commissions can be called at both state and federal level, the latter being commissioned by the Crown through the Governor- General (Prasser & Tracey, 2014). Reviews and/or inquiries therefore can be multi-faceted, depending on (1) who commissions them, i.e.,

which level of government and (2) the remit required to inform policy development and determine responses to previous policy changes or a specific set of issues that require review (Prasser & Tracey, 2014; Regan, 2017; Tjandra, 2022). While inquiries and commissions inform policy, there is some scepticism regarding their value from both a policy perspective and their fiscal or monetary value (Carling, 2023; Krasovitsky, 2023; Phillips et al., 2018).

3.9 Aged Care Reviews and Inquiries

While a lot of attention has focused on the multiplicity of reports since the Productivity Commission report in 2011, reviews and inquiries have been very commonplace. as governments of the day seek to manage the interplay between the health and age care sectors, the dynamics of health funding and the deinstitutionalisation of other sectors within the human services portfolios (Cahill & Toner, 2018; Davidson, 2011; Fine & Davidson, 2018; Henderson & Willis, 2019).

3.9.1 Consumer and Choice

The first major amendment to the *Aged Care Act 1997* (Cth) was a result of the *Caring for Older Australians* report (Productivity Commission, 2011). This report and its recommendations ultimately led to the *Living Longer Living Better Act 2013 (LLLB)* (Cth). Together the policy rhetoric was about consumer and choice with regards to care (Butler, 2013). A major recommendation was the provision of a "Gateway" or portal to enhance transparency and support choice through greater access to information about options and providers. The Gateway was also the first step with regards to access or entry to the aged care system.

Because of this new change, the government legislated and established a National Aged Care Sector Committee to advise it on policy development and implementation of the reform. This Committee was tasked with codesigning the aged care system of the future based on the recommendations from both the *Caring for Older Australians* report (Productivity Commission, 2011) and the *Living Longer Living Better (LLLB) 2013* (Cth) amendment to the *Aged Care Act 1997* (Cth). The initial Ministerial press release relating to the Committee, announced the appointment of David Tune PSM to lead this sector committee, (see link) (David Tune to Chair Abbott Government's Aged Care Sector

Committee | Former Ministers and Parliamentary Secretaries). In addition to its final reports, the Committee issued communiqués following their meetings, which were available on the archived government website (https://apo.org.au/organisation/73955)

The committee membership included representatives of aged care peak bodies or lobby groups, large for-profit and not-for-profit providers, consumers, unions and members of the Department of Health and other statutory government-related agencies. **Table 13** Aged Care Sector Representation provides further details on the advocacy focus associated with the representation to this Committee. This was a critical aspect of the situation that forthcoming chapters will return to in terms of informing understandings of power.

Table 13 Aged Care Sector Representation

	Representative agency	Role
Provider lobby Group	ACSA	Aged & Community Services Australia (ACSA) is the leading peak body supporting church, charitable and community-based not-for-profit organisations that provide accommodation and care services to older Australians. ACSA is a national entity representing approx. 70% of the NFP providers across Australia in metropolitan, regional, rural and remote regions, through sector leadership, support and advocacy. Over the decade of 2011-2021 ACSA moved from a state-based operating model to a national model. Exact numbers are fluid as consolidation and closure occurred.
	LASA	Leading Age Services Australia (LASA) is the national peak body representing all providers of age services across residential care, home care and retirement living. LASA's vision is to create a high performing, respected, sustainable aged services industry delivering affordable, accessible, quality care and services for older Australians. Following a move to a national model, LASA represented approx. 70% of the for profit providers.
	The Guild	The Aged Care Guild is an association of the nine largest residential aged care for-profit providers in the industry. The Aged Care Guild's purpose is to support ongoing investment in the industry to meet future demand. It controls circa 18% of the industry beds (or 35,500 places) and holds $5bn of the circa $20bn bond pool. Collectively it has been the largest builder or acquirer of beds in the industry.

	Not-for-profit, faith-based	This includes Catholic Health Australia, representing the large number of Catholic health and aged care services (> 27,000 aged care beds and 53,000 home care places) and UnitingCare Australia, which represents the state-based UnitingCare providers' home and residential care service provision to 8.0% of the Australian total residential care and 8.5% of Home Care packages. Representatives from these faith based groups could also be members of ACSA. They also were advocates for vulnerable and concessional people in policy debates.
	Representative agency	**Role**
Older Australian Peaks	COTA	COTA Australia is the national policy and advocacy arm of the COTA Federation which comprises COTAs in each state and territory. COTA Australia focuses on policy issues from the perspective of older people as citizens and consumers. COTA receives government funding.
	NACA	The National Aged Care Alliance (NACA) is a representative body of peak national organisations in aged care, including consumer groups, providers, unions and health professionals. NACA advocates for better outcomes for the care of older Australians, particularly in the areas of consumer rights, quality of care, workforce planning, and short- and long-term financing of aged care.
	National Seniors Australia	National Seniors Australia (NSA) was established in Queensland in 1976. With more than 200,000 members, 140 branches and 70 employees, NSA is a not-for-profit consumer lobby for older Australians
	Carers Australia	Carers Australia is the national peak body representing Australia's carers. It takes a leadership role and responds to carers' needs and those of the people they care for, being mindful of their financial challenges and in many cases a lack of social inclusion.

	Dementia Australia	Dementia Australia is the charity for people with dementia and their families and carers. As the peak body, it provides advocacy, support services, education and information.
	Independent Representation	Two independent executive members
	Representative agency	**Role**
Union	ANF	The Australian Nursing and Midwifery Federation (ANMF) is the largest professional and industrial organisation representing registered nurses, enrolled nurses, midwives, and assistants in nursing working in every state and territory.
Government-related agencies	Department of Health	Australian Department of Health
	ACFA	The Aged Care Financing Authority provides independent advice about aged care funding and financing to the Australian Government. In preparing advice for government, ACFA has to consult with consumers, the aged care sector and the finance sector regarding these issues. ACFA is also required to provide an annual report on the funding of the aged care industry.
	Aged Care Quality Advisory Council	The Aged Care Quality Advisory Council is responsible for providing advice to the Australian Government and the Australian Aged Care Quality Agency on its functions and operations.

As referenced earlier, within the *LLLB Act* was a mandated legislative review. This review commissioned David Tune PSM to review the speed of the reform, initiated by LLLB in 2017. Further reviews were simultaneously reviewing the activity-based funding models and pricing for the aged care sector. These were *The Review of the Aged Care Funding*

Instrument Report (Rosewarne et al., 2017) and the *Alternative Aged Care Assessment, Classification System and Funding models* (Eagar et al., 2019).

Sector capability was also reviewed over this time. For example, The Aged Care Workforce Strategy *A Matter of Care* (Pollaers, 2017) was a key initiative to address the workforce challenges that were becoming more apparent, especially due to an ageing workforce, barriers for recruitment and retention and increasing competition with other social service streams offering higher remuneration e.g., disability.

However, during this time, stories of abuse started to increase, with the sector citing increased financial pressures due to removal of subsidies, more costly service challenges and workforce challenges. While these reviews mirrored the preceding history of aged care in Australia pertaining to how the government of the day would respond to the rising demand for aged care, there had also been reviews associated with actual and perceived quality failures within the sector.

3.9.2 Scrutiny and Regulatory Responses

Aged care in Australia is not unusual in facing significant scrutiny associated with care provision and reviews of its failures have typically increased regulation of the sector (Braithwaite et al., 2007; Ellis & Howe, 2010). As the sector has evolved, so too have its regulatory requirements to ensure (and assure the community) that care is being delivered to a specified standard. These standards are governed, as discussed, by both the *Aged Care Act, 1997* and the *Aged Care Quality and Safety Commission Act 2018* (or the relevant act at the time), which administer and govern the regulatory processes. Over the period 2011–2021, the regulatory body has undergone several name changes and changes to scope, power and remit, the most recent significant change being the establishment of the Aged Care Safety and Quality Commission and the new regulatory standards, which came into effect on 1 July 2019. While the Commission has numerous regulatory functions, its accreditation process represents the most tangible and direct interaction with the sector. Over the decade of this study, the standards associated with accreditation changed from a process-focused approach (Trigg, 2018) based on four standard management systems, staffing and organisational development, health and personal care, care-recipient lifestyle, and physical environment and safe systems. "Care recipients" was the standard nomenclature to refer to the people receiving care, which was consistent with the terminology in the *Aged Care Act 1997*. Post the *Living Longer Living Better* reforms, the new regulatory standards referred to people as consumers and included consumer outcomes associated with each of the eight standards. In

addition to the explicit language of consumer and consumer outcomes, the consumer was central to the standards; for example, Standard 1 relates to "Consumer, dignity and choice" and this core aspect is depicted in the centre of **Figure 8** Australian Accreditation Standards below.

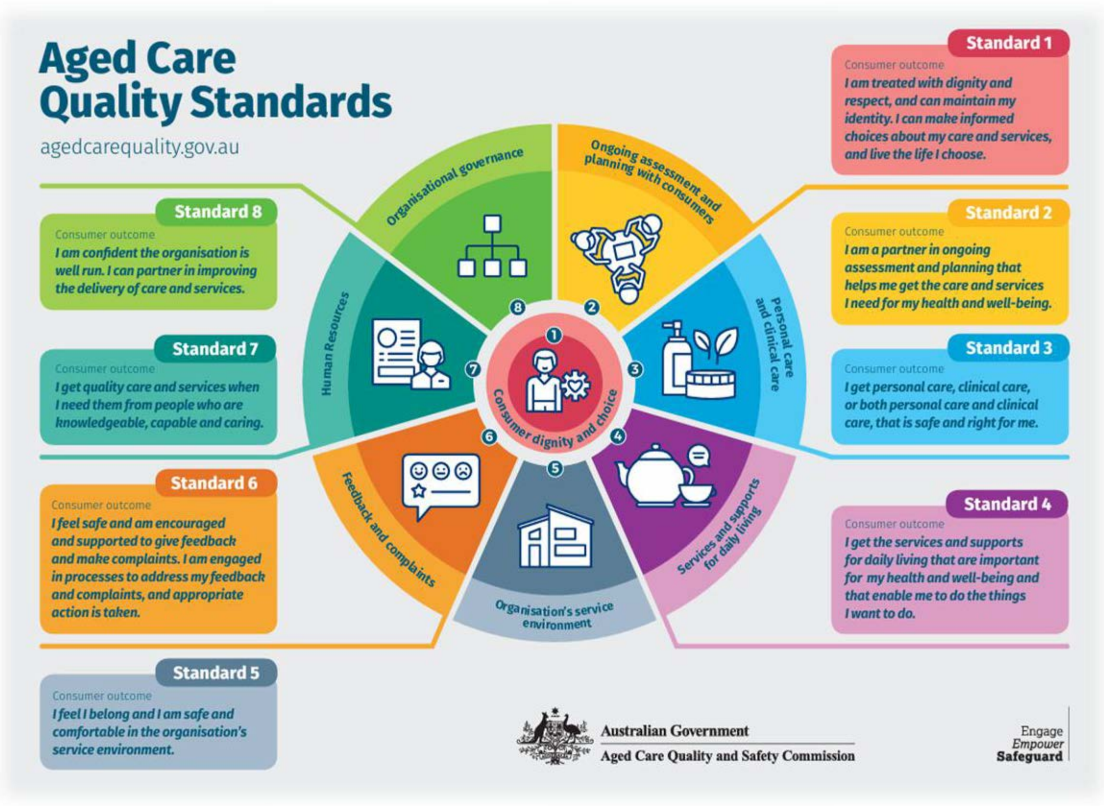


Figure 8 Australian Accreditation Standards, (Aged Care Quality and Safety Commission website, ND) (Aged Care Quality Standards Consumer Outcomes A2 poster | Aged Care Quality and Safety Commission)

3.9.3 Oakden and the Establishment of the Royal Commission into Aged Care Quality and Safety

Regulatory failures within aged care are not new, with some significant high-profile cases in recent years (Baldwin, Chenoweth, Dela Rama, et al., 2015; Carnell & Paterson, 2017; Ellis & Howe, 2010). The increasing public disquiet following notable failures and inaction, for example, Oakden failures and scandal in South Australia in 2017, resulted in the *Review of the National Aged Care Quality Regulatory Processes* (Carnell & Paterson, 2017) with associated consternation of how a service had maintained accreditation despite the failings and neglect that were uncovered (Groves et al., 2017; McKellar, 2024). Public failings led to enhanced media scrutiny, which culminated in a parallel Australian

Broadcasting Corporation (ABC) (Connelly et al., 2018) two-part investigation into the sector. These failings and the constant media scrutiny ultimately led in 2018 to the establishment of an Aged Care Royal Commission (RCACQS) into quality and safety.

3.10 Chapter Conclusion- Terms and Terminology

Since the *Aged Care Act, 1997* (Cth) became the legislative underpinning for the aged care sector, subsequent amendments and reviews have demonstrated that policy makers have shifted terminology language and approaches leading to two distinct ways of referring to people receiving aged care services. In the *Aged Care Act, 1997*, people who require services are referred to with such terms as “care recipient” while the term “person-centred” in relation to approaches is also used (Woods & Gilchrist, 2020). Post the Productivity Commission’s *Caring for Older Australians* and the *Living Longer Living Better* reforms, the term “consumer” became more common in the legislative tools of government. Indeed, the shift to “consumer” became more commonplace and gathered significant pace during the Abbott Government (September 2013–September 2015), particularly in a notable address by Senator Mitch Fifield, Minister , Assistant Minister for Social Services to the Committee for Economic Development (CEDA) wherein he stated that the “drivers of change were not government policy, demographics or fiscal pressures, but the key driver for reform would be the consumer themselves”. He went on to use “The old retail maxim, ’The customer is always right’ is being discovered more and more by government and policy makers and that consumer choice drives competition, and competition drives innovation and new service delivery” (Hon. Mitch Fifield, 2014). This speech laid the groundwork for the CDC shift and acceleration from the previous Gillard government’s LLLB changes (Woods, 2023).

These opening chapters have set the scene for the study. The literature review highlighted gaps in the process of implementing person-centred culture change that warranted further investigation. In particular, it has highlighted shifts in terminology pertaining to how people are referred to. On examination of the policy and legislative settings, it is evident that these shifts reflected government policy, reviews and inquiries. Collectively, these highlight an area for further exploration through mixed methods and the findings of which are presented in sections 3 and 4.

SECTION 2 – RESEARCH STRATEGY

4. RESEARCH STRATEGY, DESIGN AND METHODS

"Improvisation and new learning are not private processes; they are shared with others at every age. We are called to join in a dance whose steps must be learned along the way, so it is important to attend and respond". Bateson ND

4.1 Introduction

Chapter 1 demonstrated a number of key issues regarding implementation of person-centred care models in residential aged care. One of the key issues, according to some authors, is that people implementing change do not always understand the process as it applies to this field (Petriwskyj et al., 2016b; Shier et al., 2014). Another factor, and one that this research addresses, is the multiplicity of terminologies used in Australia to refer to people receiving care, in both policy and the extant literature. Yet, the impact of these policy influences has not been examined in relation to the implementation of person-centred care.

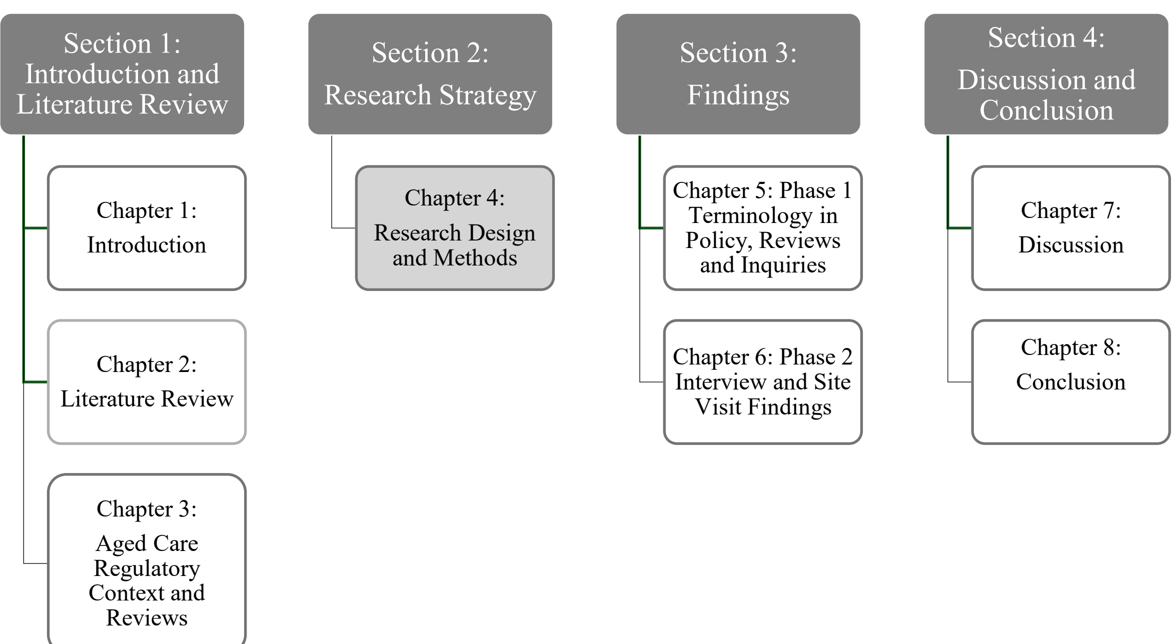


Figure 9 Thesis Outline Chapter 4

This chapter, which is a section in its own right, provides an overview of the research, including the research hypothesis, its design and methods, and consists of two sections,

(1) methodology and methods and (2) study recruitment and data collection methods based on the approach of (Paltridge & Starfield, 2019). It begins by outlining the methodology that underpins the study design and goes on to describe the methods used. Descriptions of each phase in the study, the study recruitment, data collection methods and characteristics of each interview group and the analyses used follow. The ethical considerations underpinning the study are in accordance with the Australian Human Research and Ethical Guidelines (National Health and Medical Research Council, 2018) to ensure the voluntary participation and the safety of the people taking part. **Figure 9** Thesis Outline Chapter 4 shows where this chapter is located in this thesis.

4.1.1 Declared Assumptions

Central to research is objectivity; however, to remain completely objective is an impossibility, as Crotty (2020) so aptly states:

> At every point in our research – in our observing, our interpreting, our reporting, and everything else we do as researchers – we inject a host of assumptions. These are assumptions about human knowledge and assumptions about realities encountered in our human world. Such assumptions shape for us the meaning of research questions, the purposiveness of research methodologies, and the interpretability of research findings. (Crotty, 2020, p. 17)

Hence it is important to declare my assumptions and how these have informed this study. I have worked in aged care and led change programs for many years. As with all research, we commence research with mindsets, experiences and knowledge that have shaped us. The key, therefore, is to attempt to be neutral (Robb, 2020) but also to recognise and use assumptions in a critical and informed way, rather like a puzzle or as a patchwork quilt (Debono, 2014) or as a bricoleur (Berry & Kincheloe, 2004; Holstein & Minkler, 2007). The concept of bricolage is particularly apposite in this study, as the quote below highlights:

> Methodological bricolage means not ruling out knowledge that is gained from personal narratives, fiction, poetry, film, qualitative investigations, philosophical inquiries, participatory action research and any other

> method of inquiry we may discover that yields insights into fundamental questions about how, and why, we experience old age in very particular ways. (Bernard & Scharf, 2007, p. 22)

The flexibility of bricolage has many advantages. In this research, the methodological bricolage provided a multi-faceted prism through which to examine the data and findings as they developed. This was particularly applicable as this research took place within the wider context of the Royal Commission into Aged Care Safety and Quality (RCACSQ) and the COVID-19 pandemic, the latter of which disproportionately impacted older people. As Crotty stated:

> All knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context. (Crotty, 2020, p. 42)

4.2 Theoretical Framework

Drawing from my executive and facilitation experience, I approach work pragmatically, adapting strategies as situations evolve. This pragmatism extends to my research ontology and epistemology. Pragmatism was developed by American theorists Charles Peirce, William James and John Dewey (the classical pragmatists), who rejected the philosophical dualisms posed by positivist and interpretivist schools of thinking. Pragmatism for Dewey sought to reorient philosophy away from abstract concerns towards human experience (Morgan, 2014). Indeed, it is regarded as guiding philosophical research paradigms. In this case, it is significant as it "places high regard for the reality of and influence of inner world of human experience in action (and where) knowledge is viewed as being both constructed and based on the reality of the world we experience and live in" (Johnson & Onwuegbuzie, 2004, p. 18).

Pragmatism also provides an approach to solving complex problems that remains philosophically and epistemologically flexible, allowing research methods to be determined by practical needs (Feilzer, 2024; Hall, 2013). Pragmatism as an approach is not without critics, perceived as a paradigm of convenience and lacking ontological and epistemological rigour (Hampson & McKinley, 2023). These criticisms have been

countered by a more nuanced appreciation of Dewey's work and how pragmaticism asserts that nature and experience are intertwined and reflect each other (Morgan, 2014). Furthermore, as a philosophy, it is now more widely accepted and is challenging dualist positions associated with positivism and constructivism (Feilzer, 2024). Morgan (2014), also highlights Dewey's attention and focus on social research and social justice, political implications and links to mixed methods, citing Denzin (2012):

> Classic pragmatism is not a methodology per se it is a doctrine of meaning, a theory of truth. It rests on the argument that the meaning of an event cannot be given in advance of the experience. But focuses on the consequences and meanings an action or event in a social situation. This concern goes beyond any given methodology or any problem-solving activity. (Denzin, 2012, p. 81)

In this study, where the focus of the core research questions is on the implementation of person-centred models, and the practical insights into what change implementation aspects worked and what compounded application in practice, pragmatism has obvious utility. The pragmatic lens also encouraged me to recognise the interconnectedness of the research questions, as I explored the approaches and learnings from the interviewees, and to acknowledge my own practical experience, which aligned with the maxims of Sanders, Pierce and James (Johnson & Onwuegbuzie, 2004).

In addition, there is a criticalist dimension to my thinking as I work with organisations and people to effect improvement for older people (Watkin, 2022). Bricolage aligns with pragmatic approaches, as it seeks not only to make sense of things from a variety of perspectives, with the "bits and pieces", but also to create something new or for sense-making, which is the intent of this study (Holstein & Minkler, 2007). As (Denzin & Lincoln, 2004, p. 185) said, "… seek to produce practical, pragmatic knowledge, a bricolage that is cultural and structural, judged by its degree of historical situatedness and its ability to produce praxis or action." In accordance with Kelly and Cordeiro (2020), as a pragmatist, with "an emphasis of actionable change, recognition of the interconnectedness between experience, knowing and acting and inquiry as an experiential process" (Kelly & Cordeiro, 2020, p. 3), the next section will outline the study aims and design.

4.2.1 Research Aim and Design

The gaps identified in the literature review regarding person-centred change implementation, coupled with evolving policy settings, underscore the importance of this research. This study examined how government policy language and terminology influence the implementation of person-centred care models in residential aged care, gathering practical insights into the design, approach and rationale of implementing person-centred change to determine if and how policy terminology affects practice delivery.

As mentioned in the introduction to this chapter, to achieve these objectives, I employed a mixed-method design to explore the following research questions:

RQ. 1 What are the key language and terminology shifts in aged care policy reviews from 2011 to 2021?

RQ.2 How do aged care leaders perceive the relationship between "legislative and policy terminology" and the implementation of person-centred care models in residential care?

RQ.3 What are the perspectives of aged care leaders with regards to implementing person-centred care models in residential aged care?

RQ.4 How can international perspectives inform our understanding of implementing person-centred care and compare them to the Australian context?

To answer these questions, the study was conducted using a mixed-methods approach through an explanatory sequential mixed method design, as per **Figure 10** below (Creswell, 2015).

4.3 Methodology and Justification

Mixed methods were chosen for this study due to their suitability for collecting and analysing multifaceted information to comprehensively address the research questions. Mixed-methods research is an approach that combines quantitative and qualitative research methods in the same inquiry. Such work can help develop rich insights into various phenomena of interest that cannot be fully understood using only a quantitative

or a qualitative method (Creswell & Creswell, 2017; Wise, 2018). Mixed methods as a research approach is particularly valuable in health and social care research, where issues are often complex and understudied (Doyle et al., 2009, 2016; Greenhalgh et al., 2019; O'Cathain, 2009; Travaglia & Braithwaite, 2009). Mixed methods also enable both deductive and inductive reasoning, facilitating theory validation and development (Creswell, 2015). Creswell (2015) identifies three basic mixed methods designs: convergent, explanatory and exploratory. The approach used in this research integrated various methodological elements, including worldview considerations, design preferences, sampling strategies, and quality assessment criteria (Teddlie & Tashakkori, 2009, 2011). Finally, the flexibility of mixed methods aligned well with my pragmatic philosophical perspective and extensive experience in the Australian aged care sector.
Mixed methods and pragmatism are particularly aligned from a philosophical perspective (Creswell & Clark, 2017; Johnson & Onwuegbuzie, 2004; Johnson et al., 2007; Teddlie & Tashakkori, 2011). Together, these approaches and framework help users to understand multiple perspectives and create actionable research (Johnson et al., 2007; Kelly & Cordeiro, 2020). Ultimately, they adhere to a dialectical perspective by taking multiple world views into account, where practice-to-theory and theory-to-practice continually inform each other and where all participants are working towards a win-win situation. In this case, the transformation of aged or long-term care all "dovetailed with the research questions being investigated" (Bryman, 2008; Mertens, 2003; Schoonenboom & Johnson, 2017).

Further, the research was undertaken against the backdrop of the Royal Commission of Inquiry into Aged Care Quality and Safety (RCACQS), which added to the complexity of the context. Indeed, the amount of information collated and requested through the RCACQS was rich and complex and, and in some instances, freely available for the first time; to illustrate, Cabinet-in-confidence minutes (Chapter 7, 5.4). The RCACQS were themselves commissioning additional reviews that were relevant to the research questions in this study. Consequently, the explanatory sequential mixed-methods design and research approach further suited the dynamic nature of the study, given the complexity of the available information being released.

Mixed methods, as the name implies, involves the intentional collection and mixing or integration of both qualitative and quantitative data collected (Teddlie & Tashakkori, 2011). Explanatory sequential mixed-methods design begins with a quantitative strand, based on the findings of which the second, qualitative strand draws inferences, insights, explanations and conclusions pertaining to the research questions (Creswell & Clark, 2017; Greenhalgh et al., 2019; Pope & Mays, 2020). In accordance with Morse (1991), using the notation for mixed-methods designs, the explanatory sequential mixed-method design underpinning this study can be summarised as (QUAN + qual) QUAL. The capitalisation of QUAN and QUAL as outlined by Morse implies the equal priority in both phases. The content analysis in Phase 1 includes a qualitative component; however, the lower case indicates that it was secondary and was used to contextualise the quantitative findings and prepare the questions for the semi-structured interviews (Morse, 1991).

The research was conducted in three phases, with each phase building on the previous and phase and allowing further exploration of the findings. **Table 14** Phase Overview shows how each of these approaches was then mixed or triangulated to answer the research questions.

These phases were Phase 0 Literature Review, Phase 1 Policy Review and Phase 2 Interviews and Fieldwork, each which is discussed in the next sections. The following table shows how these phases were translated into thesis components.

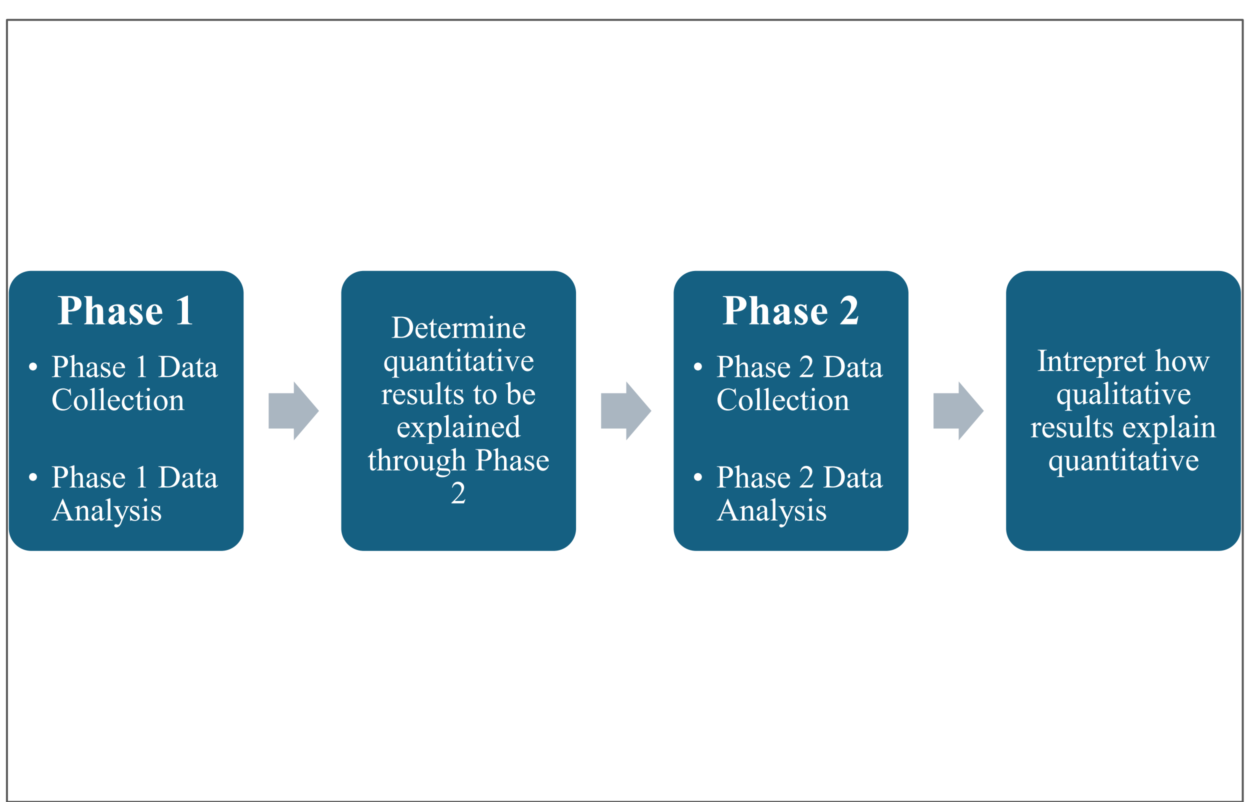


Figure 10 Explanatory Sequential Mixed-Method Approach

Table 14 Phase Overview

Phase	Research task	Objective	Research methods	Data collected	Analysis	Outputs
Phase 0	Review current literature on implementing person-centred care in residential aged care.	To map the development of cultural change in aged care.	Search of key databases. Hand search of key journals. Snowball of citation classics. Review of key websites, including patient safety organisations and advocacy websites.	Peer reviewed literature. Grey literature. Websites. Connected papers.	Evaluation of research reports and analysis of research findings. Synthesis of extant literature.	Chapter 2
Phase 1	Review key Australian Government legislative settings, policy reviews and inquiries.	To examine and understand the role of inquiries and reviews as they pertained to the legislative underpinnings and the language used to refer to people.	Detailed examination of content, policy shifts and changing terminology.	Interim and final inquiry reports (policy documents, guidelines). Submissions to inquiries. Media reports of inquiries, prior, during and after studies, commentaries.	Quantitative and Qualitative content, narrative and story analysis of submissions and reports undertaken by traditional and automated Leximancer content analysis methods. Comparison of differences in concepts, and terminology for people.	Chapters 3 and 5

Phase	Research task	Objective	Research methods	Data collected	Analysis	Outputs
Phase 2	Investigate views of aged care professionals about cultural change, approaches, rationale and language.	Interviews with aged care leaders.	47 interviews with researchers, facilitators and Australian CEOs and board members.	Opinions regarding the implementation of person-centred care models, the rationale and approaches to implementation. The role of the legislative pillars and the language of policy on the implementation process,	Interview transcripts analysed through traditional, statistical and automated content analysis i.e., NVivo	Chapters 5 and 6

4.3.1 Methods

The previous section outlined the methodology underpinning the present study. This section provides an overview of the methods associated with the empirical work, the related analysis for each phase and the mixing of the results.

4.4 Phase 1 - Policy Review

This phase contained a formal review of Australian Government’s reviews and inquiries into the aged care sector.

4.4.1 Reviews and Inquiries

Considering the changing terms to refer to people identified in the Australian studies in the literature review, it was important to understand the policy context to determine what had shaped the sector. Aged care in Australia is governed by legislative frameworks and obligations, as outlined in chapter 3. Further, the accountable federal government of the day commissions and conducts policy reviews as part of its remit. These reviews are conducted with clear terms of reference, using a variety of approaches, interviews, roundtable working sessions and submissions. The reports are typically tabled with the relevant minister and department for further review and the government considers and responds to the recommendations. The reports from these reviews are commonly published and are publicly available as per parliamentary guidelines. This study reviewed easily accessible reports to analyse how older people were referred to in Australian aged care policy. The methodology involved several steps: compiling a comprehensive list of reviews, examining the terms of reference to understand each review’s impetus and scope and conducting initial readings of both interim (where available) and final reports. Content analysis was then performed through two distinct methods. The first was a search-and-count of terms regarding how people were referred to in these documents (as reported in Chapter 5). Second, and more detailed, was the use of Leximancer, a text analytic tool that provides a visual display of the content of textual documents.

4.4.2 Automated Content Analysis

The capabilities and specificity of data mining software have increased exponentially in recent years, driven by the growing volume of available data. The Leximancer data

mining program performs an automatic form of content analysis based on Bayesian logic (Smith & Humphreys, 2006), identifying concepts as "a group of related words (terms) that travel together in the text" (Leximancer, 2021) in a corpus of data. It then uses an algorithm to calculate the strength of the relationships between concepts. These machine learning capabilities enable the software to conduct both thematic and semantic analysis of textual data. The Leximancer software displays a map of the main concepts or themes in various colours depending on frequency. These concept maps are interactive and allow the researcher to explore the concepts contained in themes and how they relate to each other. Leximancer tags or codes sentences in two-sentence blocks. In addition to the concept map outputs, the package also produces charts and textual content (Leximancer, 2021).

4.4.3 Justification for the Use of Leximancer

Leximancer was selected over alternative software programs for the following reasons:

1. practicality (ease of use, support from the developers and available webinars),
2. objectivity (Leximancer automatically generates concepts, removes researcher bias and allows for inferences to be drawn across the multiple phases of the study) and
3. interactivity (Leximancer allows the researcher to explore concepts, their connections with each other and their links to the original text).

These claims were substantiated by Gibson, (Gibson, ND) who compared alternative programs such as MAXQDA, NVivo and ATLAS.ti to Leximancer and highlighted seven key features where Leximancer excelled: automated content analysis, dynamic concept mapping, thematic analysis, sentiment analysis, ease of use, scalability, speed of analysis and objective results, thereby reducing subjectivity and researcher bias. These features were further validated by Biroscak et al., (2017).

4.4.4 Content Analysis with Leximancer

Leximancer represents concepts in two ways: visually, in the form of a concept map, and as a ranked list. A Leximancer map represents the concepts in the data as dots of varying sizes (and colours). The size of the dots represents the importance of the concept (more

prominent concepts appear as bigger dots or circles on the map). Their relationship to each other is represented by their position on the map (the closer the concepts appear on the map, the stronger the relationship between them).

Concepts are also grouped on the map into themes. Themes are a “group or cluster of concepts that have some commonality or connectedness as seen from their close proximity on the Concept Map” (Leximancer, 2021). These are depicted on the map by transparent circles and the themes are automatically labelled by the program.

A central aim of this study was to examine how the language and terminology used in government policy influences the implementation of person-centred care models in residential aged care. To understand this, it was critical to understand Australian aged care policy and associated governmental reviews over the period of 2011 to 2021, to determine the terminology and language in use that underpinned aged care delivery. Content analysis was the method of choice for this question, providing an “analytic approach that quantifies content in terms of predetermined categories in a systematic and replicable manner” (Liamputtong & Serry, 2013).

A purposive sample of reviews and inquiries was identified for content analysis, as listed in **Table 15** Major Australian Government Reviews and Inquiries 2011-2021. These were reviews and inquiries that had resulted in policy change and /or new legislation based on the authors’ experience in the sector. The key terms reviewed in these reports and revealed in the literature review were “customer”, “client”, “consumer”, “person” and “care recipient”. Each of the reports was read and hand searched, then analysed using Leximancer software.

Given the of the review/ inquiry outputs Chapter 5 contains an analysis of selected (bolded) reports from 2011 onwards, which constituted the purposive sample.

Table 15 Major Australian Government Reviews and Inquiries 2011-2021

Report	Year	Author	Commissioner	Location
Caring for Older Australians	**2011**	**Productivity Commission Inquiry Report**	**Department of Health and Aged Care**	**Included in chapter 5**
Aged Care Roadmap	**2016**	**Aged Care Sector Committee**	**Department of Health and Aged Care**	**Included in chapter 5**

Report	Year	Author	Commissioner	Location
Alternative Aged Care Assessment, Classification System and Funding Models	2017	Eager et al.	Department of Health and Aged Care	
Legislated Review of Aged Care	**2017**	**Tune**	**Department of Health and Aged Care**	**Included in chapter 5**
Review of the Aged Care Funding Instrument Report	2017	Rosewarne et al	Department of Health and Aged Care	
Review of National Aged Care Quality Regulatory Processes	**2018**	**Carnell Patterson**	**Department of Health and Aged Care**	**Included in chapter 5**
A Matter of Care: Australia’s Aged Care Workforce Strategy–	2018	Pollaers	Department of Health and Aged Care	
Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised	2018	Australian Senate, Community Affairs References Committee	Senate Committee	
Interim Report: Neglect	**October 2019**	**Hon. Richard Tracey AM, RFD, QC (deceased) and Ms Lynelle Briggs AO**	**Royal Commission into Aged Care Quality and Safety**	**Included in chapter 5**
Aged care and Covid-19: A special Report	October 2020	Hon. Tony Pagone QC and Ms Lynelle Briggs AO	Royal Commission into Aged Care Quality and Safety–	5
Final Report: Care, Dignity and Respect	March 2021	Hon Tony Pagone QC and Ms Lynelle Briggs AO	Royal Commission into Aged Care Quality and Safety-	5

Leximancer Process and Analysis

The five reports were loaded separately in Leximancer software package, following the process outlined by Leximancer manual with regards to uploading and running the preset algorithms. The inbuilt interactive features, for size of Concepts, themes and/ or rotation

of circles were used to aid visualisation. The outputs were also reviewed for any ambiguous terms. Map settings and outputs were discussed with my supervisors, in particular, Professor Travaglia an advanced Leximancer user (Travaglia & Braithwaite, 2009), and also with Professor Smith the founder and developer of Leximancer for advanced features and analysis (Smith, 2024). The findings from this phase let to the design and methods for phase 2

4.4.5 Phase 2 - Interviews and Site Visits

In Phase 2, semi-structured, online face-to-face interviews were conducted to understand the findings observed from the first two phases, through the perspectives of aged care leaders with experience in implementing person-centred change models. Site visits were also conducted to observe language and person-centred practice in context. Interviews and site visits were conducted in 2020, during the COVID-19 pandemic. This section describes this phase of the study, including the design of the interview guide, ethics approval, recruitment of interviewees, the data collection procedures and the analysis methods.

4.4.6 Design of Interview Guide and Ethical Considerations

A semi-structured guide was used for Phase 2 to explore the gaps identified from the literature review in Phase 0, the findings from the Phase 1 content analyses and the research objectives. This semi-structured approach not only guided the interview process but also provided the interviewees a degree of spontaneity and opportunity for more narratives and descriptions (Serry & Liamputtong, 2010; Brinkman, 2008; King & Horrocks, 2010). The interview guides were reviewed and approved as part of the ethics approval process (see Appendix 9.3).

The semi-structured interview questions were developed with prompts and follow-up questions included to allow further elaboration, for clarification or to seek explanation (Serry & Liamputtong; 2010). The broad focus areas of the questions related to the following:

- Personal perspectives relating to:
    - what person-centred approaches meant to the interviewees
    - collective terms used in policy to describe people receiving care

  - the legislative pillars with regards to implementing person-centred change models
- Models and delivery approaches to implement person-centred models in organisations
- Rationale for undertaking a renewed focus on person-centred models in organisations
- The local governance and risk management associated with implementing person-centred models

To garner the widest responses to the research questions, the semi-structured interviews were conducted with two different groups of people, as follows:

- Group 1. International academics and thought leaders who had studied or designed transformational change programs in aged care
- Group 2. Australian aged care executives and board members

4.4.7 Sampling Strategy

Purposive sampling is widely used in selecting interviewees who share perceptions and experiences that are relevant to a study's aims and the research questions under consideration (Liamputtong & Serry, 2013). Consequently, selecting people is based on the judgement of the researcher and the research questions associated with the study.

The literature review had revealed a number of terms in use to refer to older people, notably "consumer", "client", "customer", "care recipient" notably in the Australian authored literature. As an executive myself, I knew many executives across Australia, which included people who had experience in both leading organisations and in the policy environment. These executives and their perspectives were therefore extremely pertinent to the research questions. In addition, I had previously researched a number of person-centred models of care when charged with leading the implementation of a new person-centred model of care in one of Australia's largest residential aged care organisations. This leadership role had brought me into contact with designers of person-centred models of care internationally through conferences and workshops. Interviewing experts is not without controversy, particularly relating to the question of who determines and bestows the "expert" status and whether they influence the researcher or truncate the investigation

(Trigg, 2018). Bogner et al. (2009) provide practical reasons for their inclusion, assisting with other interviewees in purposive sampling and snowballing. (Bogner et al., 2009).

4.4.8 Participant Recruitment and Involvement

Interviews and Interviewees

Semi-structured interviews were used to explore and address research questions 2 and 3 and part of 4, as outlined below.

> RQ.2 How do aged care leaders perceive the relationship between “legislative and policy terminology” and the implementation of person-centred care models in residential care?
>
> RQ.3 What are the perspectives of aged care leaders with regards to implementing person-centred care models in residential aged care?
>
> RQ. 4 How can international perspectives inform our understanding of implementing person-centred care and compare them to the Australian context?

Group 1. A purposive sample of key international experts (n=13) were approached; these leaders were people who, based on a review of the academic literature, were identified as having studied, designed, evaluated and/or implemented person-centred change programs in the aged/long term/social care sectors in Canada, the USA and the UK. A number of these participants were facilitators for the various subscription-based change programs (Petriwskyj et al., 2016b) and had developed, designed and assisted aged care providers with their implementation. A number had worked closely with Australian providers regarding implementation of person-centred models. A number also served on global committees for age related issues and understood the Australian aged care sector. They therefore had deep academic, research and practical knowledge and insights to assist with this research.

Group 2. The second set of interviewees comprised a purposive sample of key leaders (n=34) who were or had been executives in aged care. Through conference presentations, and networking, these providers are known or believed to be known for having implemented person-centred care to various extents over the previous years. They

represented providers of all types of aged care in Australia, including large multisite and/or multistate, small sole site, not-for-profit and for-profit, publicly listed and family-owned and operated organisations and they included executive members and/or board members of these organisations. The sample was geographically dispersed across Australian states and territories so as to sample those who had characteristics or experience most relevant to the research objectives of implementing person-centred care models across diverse locations. This broad representation of provider type ultimately added to the applicability of the results in increasing the understanding of implementing person-centred models in residential care.

The sample sizes of both these groups were guided by the concept of "information power", postulated by Malterud et al. (2016), which proposes that when sampling participants who hold information that is highly relevant to the study, a lower sample size is needed. The concept "information power", focusing on data content and relevance, contains five items and dimensions based on the study's (a) aim, (b) specificity, (c) use of established theory, (d) quality of the dialogue and (e) analysis strategy. (Malterud et al., 2016, pp. 1754-1756). Sample size is determined with regards to where on the continuum of each of these items and dimensions the study sits.

Research is rarely conducted in a vacuum and as mentioned earlier, the emerging COVID-19 pandemic added further complexity, logistical and practical challenges to the data collection. The concurrent RCACQS provided a further challenge as providers were particularly sensitive about access to individuals and data, given that the powers of a royal commission are broad and far-reaching, and their remit is largely forensic, causing an additional operational burden.

As an aged care executive, I was very conscious when approaching the interviewees in both groups that COVID-19 was impacting to various degrees the interviewees in their personal and professional lives in all the countries included in this study. Some Australian participants were also navigating the RCACQS and therefore had additional professional responsibilities. Every consideration was offered to minimise disruption to professional responsibilities and potential stress. Prior to interviews and again at the beginning, given the uncertainty associated with COVID-19, I asked the interviewees if they were still able

to proceed or if they wished to reschedule to a more suitable time due to unexpected internal issues in their organisations which required their attention.

Participant Approach

Potential interviewees were approached with an introductory email, which outlined the study and had the participant information and consent sheets attached. These invitations stated that participation was voluntary and noted the unique circumstances impacting day-to-day operations associated with both the Royal Commission and COVID-19. Apart from one executive handling a COVID-19 outbreak, all responded positively to the interview request. Prior to the interviews, I reviewed their organisations' websites to familiarise myself with the language and terms in use in their practice setting.

4.4.9 Interview Process

All the interviews occurred between June 2020 and January 2021, and each lasted from 45 minutes to two hours, with the median being 75 minutes. The semi-structured interviews were conducted over the videoconferencing platform Zoom. They were audio recorded so that the interviewer could remain engaged and focused on the conversation and use prompts as required to clarify responses. The semi-structured format allowed for a more natural conversational interview yet yielded rich data in the responses to the questions outlined below (Kelly et al., 2010).

The rationale for the study was given at the outset of each interview. Interviewees were asked if they had any questions regarding process or the study prior to the commencement of the interview, and these were answered. Consent for participation and consent for the interview recording were obtained prior to commencement. Also, given the changing dynamic due to the pandemic with work processes, there was a check-in to ensure that the timing and their work situations were still satisfactory to proceed.

The opening questions asked the interviewees to describe their current role in their organisation and how long they have held that position. The first question was to ascertain what their perceptions were regarding the term “person-centred care”. The interviews then proceeded to understand how they as providers had sought to change their model of care and to ascertain the impetus and rationale for undertaking the change process, with

probes such as policy shifts, realignment to mission and vision, the lessons learnt, the complexity associated with the change journey, how they had undertaken the change and how the change was planned and delivered. They were asked if they used internal or external consultants and models to support their implementation of person-centred change and how and if all levels of the organisation had been involved in the change process. Had they informed the regulatory agencies and their perceptions of how the policy and legislative pillars supported the change? They were also asked about the language used in their organisations to refer to people receiving care. In terms of language, they were asked what their perceptions were with regards to the terms identified in the policy and literature, that is, "client", "consumer" and "customer", and if these were terms used in and across their services.

At the end of the interview, each interviewee was thanked verbally and with a follow up email. The transcripts were sent to a professional transcription service provider and on return checked for completeness. Each interview transcription was checked for accuracy by re-listening to the audio file. I also reflected on the conversation and made notes on key points, and these were shared with my supervision team. Transcripts and audio recordings were securely stored on a password-protected computer. Once transcribed, each file was de-identified as per protocol.

4.4.10 Interview Analysis

The interview transcripts were managed and analysed using NVivo 12, which also assisted with coding and data visualisation. The interviews were transcribed and de-identified, as outlined above.

A two-stage data analysis was conducted following the six phases of reflexive thematic analysis outlined by Braun and Clarke (2022) (see **Table 16** Braun and Clarke (2008) - Reflexive Thematic Analysis Steps). The transcripts were then read and reread and initial insights noted. Step 2 proceeded with a more granular analysis of each of the transcripts, identifying segments of data as they related to the core questions, noting broad patterns within the data and identifying initial themes throughout the data set (Braun & Clarke, 2006, 2013; Clarke & Braun, 2017). These were then coded using NVivo.

Table 16 Braun and Clarke (2008) - Reflexive Thematic Analysis Steps

Phases	**Process description**
1. Familiarisation with the data	Transcript reading and rereading, noting initial insights.
2. Coding	Systematically noting interesting features throughout the full dataset.
3. Generating initial themes	Codes collated into potential themes based on the data, the research questions and the researcher's knowledge and insights.
4. Developing and reviewing themes	Themes are reviewed against the coded extracts and relationships reviewed and revised as required.
5. Defining and naming themes	Further refinement to ensure the theme tells a "story" and the theme is named.
6. Writing up findings	Following further reflexivity, vivid extracts are determined for write up that tell a compelling story associated with the research questions.

Step 4 included the review of the codes and the extracts and use of the visualisation tools in NVivo regarding the linked themes and their interrelationships. These early identified themes were discussed with the supervision team, and iteratively reviewed and revised based on the literature, rereading and reviewing transcripts (Clarke & Braun, 2017).
Figure 11 shows the iterative process by which analysis was conducted, informed by Braun and Clarke (2017).

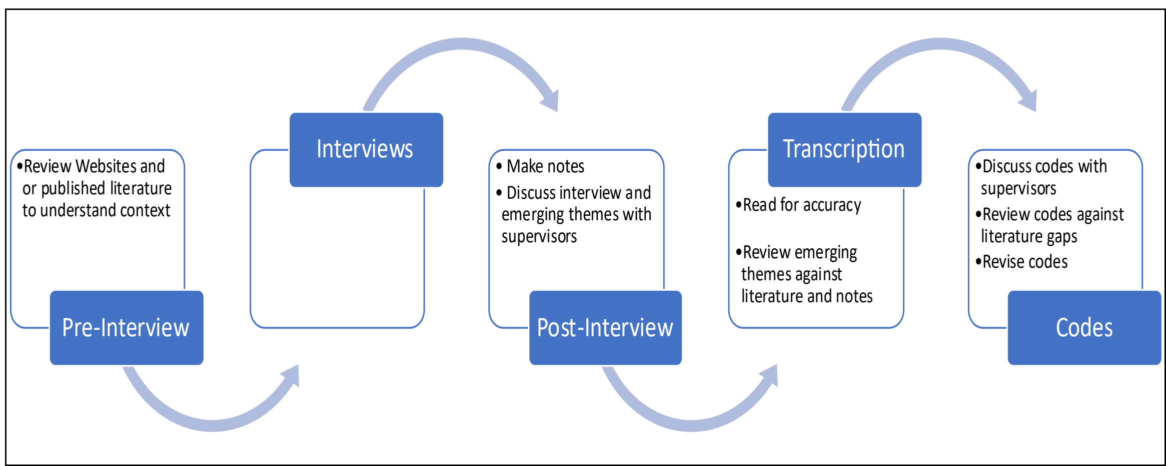


Figure 11 Data Analysis Process

4.4.11 Integration- Joint display and Meta-Inferences

A key aspect of mixed methods research is the integration of data. Greene (2007, p. 125) states the integration of the various facets of a mixed methods study is what "constitutes the very heart of mixed methods inquiry", though this is not without issue for researchers (Creswell & Clark, 2017). Integration occurred at a number of points in this study. The literature review revealed shifting terminology used to refer to people in Australian studies. This finding informed the explanatory sequential mixed methods design and the review of the legislative policy and review landscape (Phase 2). Subsequently, both the Phase 2 findings and the literature review guided the development of the semi-structured interview protocol.

As a final step, the data from both phases were integrated into a visual joint display to ascertain new insights (Creswell, 2015; Fetters et al., 2013). A joint display in mixed methods research is defined as

> … the process of studying, examining, or investigating how to bring together or link qualitative and quantitative data in one or a series of visual representations with the intent of 1) identifying commonality between the two types of data, and 2) gaining a more robust understanding of what both types of data mean together by drawing conclusions or meta inferences based on combined findings. (Fetters & Guetterman, 2021, p. 259)

Joint displays are a central feature in mixed method data analysis (Fetters & Guetterman, 2021). This additional step provides added strength and more than can be realised from a

mono-method approach. The findings from this final step of combining both the first and second phases of the study helped realise significant meta-inferences (Onwuegbuzie & Combs, 2010; Younas, Fabregues and Creswell 2023). The meta-inferences provided meaningful explanations for the influence of policy and reviews on the implementation of person-centred change models in residential aged care. Creswell states that this can be discussed in a number of places, including the discussion or conclusion section of a study (Creswell, 2015, p. 84). In this study, the joint displays are in Appendix 9.6 and discussed in chapter 7, section 7.1.

The process of realising meta-inferences involved progressing both inductively and deductively through the empirical findings from both phases. During the process, a number of latent themes were identified that could be explained only by exploring wider theoretical perspectives; this resulted in the need for an abductive approach (Mitchell & Education, 2018). The flexibility that abductive inference accords is that it allows the researcher to consider alternative theoretical approaches. Various theoretical perspectives were considered, though in this instance using Bourdieu was deemed to be the most apposite, as demonstrated in the discussion, chapter 7.

The process of drawing meta-inferences was also managed through NVivo. The findings for both Phase 2 and Phase 3, including results and thematics of interviews and fieldnotes, in addition to the findings chapters (chapters 5 and 6), were combined and analysed thematically using inductive and deductive approaches, as described above.

4.4.12 Site Visits

Site visits were planned and received ethical approval. The purpose of these visits was to observe the implementation of person-centred models in practice settings. The observational method to be used was a validated tool, *Artefacts of Cultural Change* (Bowman & Schoeneman, 2006), released by the Centres for Medicare and Medicaid Services, as a framework for the observations. Despite approval to visit, the public health orders pertaining to visits to residential care sites and travel restrictions associated with COVID-19 limited this phase as originally envisaged.

The observational methods were used in Australian provider practice settings with a subset of the providers interviewed. Interviews provide information on participants' attitudes and beliefs, whereas observation provides information about how organisations

and people work in practice and interrelationships among staff and between staff and residents (Wise, 2018). My observations therefore provided insights into language in use and the legislative pillars as they translated into the practice contexts associated with questions 3 and 4; they also corroborated findings from other methods (Pope & Mays, 2006). The *Artefacts of Cultural Change* (ACC) (Bowman & Schoeneman, 2006) is a validated tool available for public use in the USA, supported by the Centers for Medicare and Medicaid and used by a peak body– the Pioneer Network (now rebranded as AgingIN™)– to benchmark provider members' "change journey". The tool has been supported by the Commonwealth Fund (Bowman & Schoeneman, 2006). The ACC supports the assessment of artefacts that are deemed by the authors to support person-centred care in practice, (e.g., autonomy, being known, home environment, accommodation of needs and preferences, family and community, leadership and engagement). The ACC was used to guide this researcher's observations, listening to, observing and documenting the language used to describe people and care delivery in the practice setting. While a practice setting, aged care is not a health service by definition under the *Aged Care Act 1997*. While the tool looks at practice components such as bathing, dining, building design and staffing, some questions have been raised as to its appropriateness of the tool and what it seeks to answer (Grabowski et al., 2014); for example, language vis-à-vis care interactions is not considered. Despite these limitations, the tool was a useful guide for this component of the study.

Consent to visit sites was granted by the CEO or delegate, with permission also obtained from the site manager. Information and consent sheets were included, and a poster with a photograph of the researcher was provided to the sites to display on noticeboards to inform residents and their families of the study.

Prior to visiting the sites and in addition to provider websites, freely available information from the Australian Safety and Quality Commission, such as accreditation reports, customer experience reports and star ratings were reviewed, then saved and analysed for context in NVivo. **Figure 12** Site Visit Observation Approach illustrates the information collated and included.

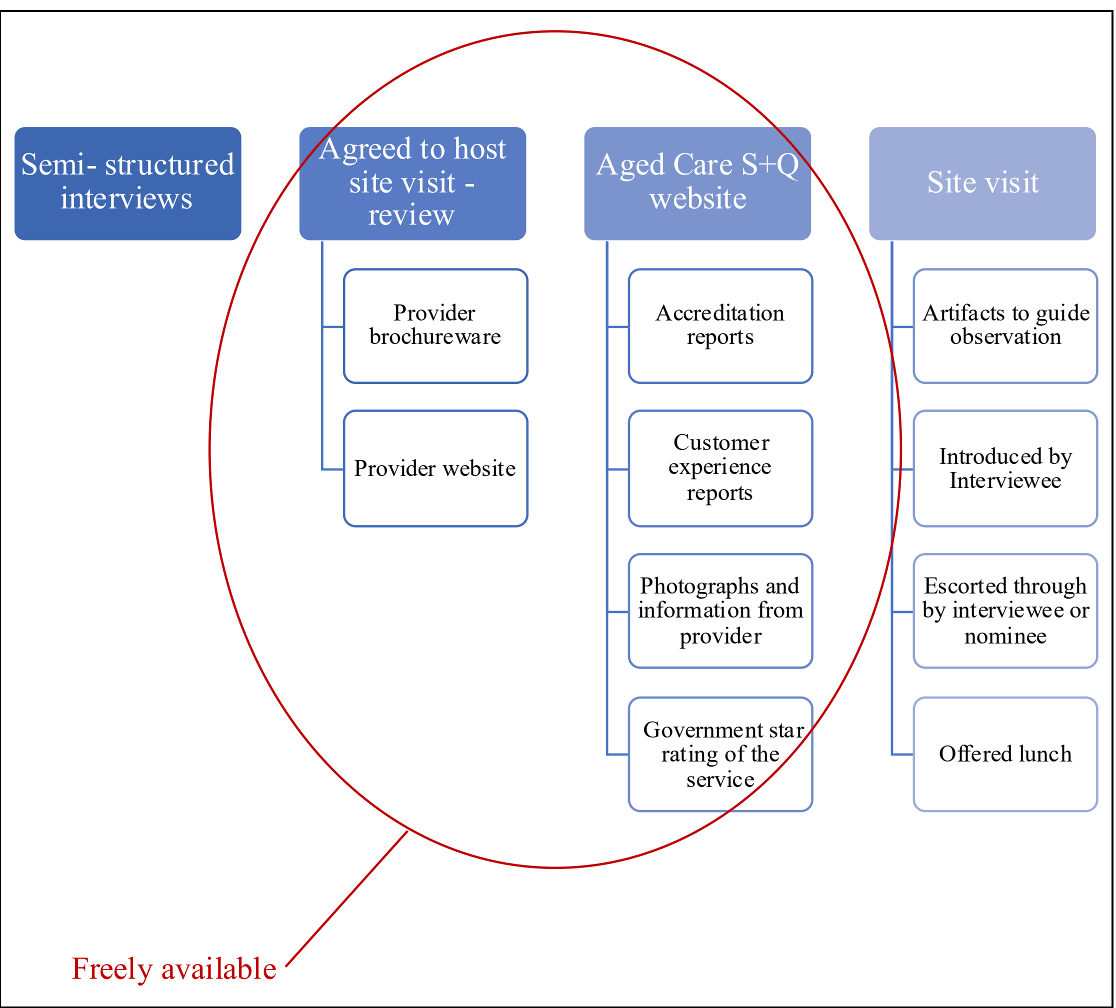


Figure 12 Site Visit Observation Approach

Nine Australian providers agreed to participate in this component of the study. As a subset, they were representative of all provider types of residential aged care provision, each had implemented major change and were seen by their peers as leaders in terms of their service provision. The COVID-19 pandemic impacted on this aspect of the study significantly due to border closures and lockdowns to protect residents. When these visits became possible due to the changing health orders, I adhered to the requirements of mandatory vaccination and COVID-19 Rapid Antigen Testing (RAT) as required for all staff members prior to each visit, and provided statutory proof at site entry. Whilst on site, I was initially met with and was escorted by the site manager. I wore a visible name badge for the duration of my visit and was as discrete as possible for the observation component of the study. The duration of each site visits was approximately three hours and included being present at either morning tea or lunch. Artefacts such as service layout, décor, logos

and branding, dress, rituals and ceremonies were collected and reviewed where possible. Notes from the site visit were recorded by the researcher immediately following and a follow-up thank-you email was sent to the provider. Each of the sites visited has been provided with a pseudonym to de-identify them.

Table 17 Pseudonyms and Designation of Sites Visited

Site		
Boronia	Small Single Site NFP	1 Interview
Banksia	Large, Multi-Site, National NFP	1 Interview
Snow gum	Large National FP	1 Interview
Kentia	Large, Multi-Site, National NFP	2 Interviews
Jacaranda	Large, Multi-Site, Single State NFP	2 Interviews
Frangipani	Large, Multi-site, Single State NFP	2 Interviews
Flame tree	Family Owned, Multi-site, Single State FP	1 Interview
Macadamia	Multi-Site Single State NFP	2 Interviews
Wattle	National FP	1 Interview

Finally, corporate communication tools, such as brochures, websites, mission statements were gathered from the publicly available websites for the participating providers prior to the visit. Each website page was saved as a PDF and all were reviewed, managed and analysed in NVivo.

The content analysis of these documents was used for descriptive purposes (context), to understand the language and terminology used to refer to people, their primacy in core documents and how these were translated into practice. While content analysis may be qualitative or quantitative, both can use the same body of textual and other data and most content analysis is now entirely quantitative (Gibson, ND). It counts the incidence and frequency of words, with its theoretical underpinning provided by Zipf's Law, an experimental law developed by George Zipf (1902-50). According to this law, where uncommon words (or phrases) are used often in plain English text, they express and reflect the greatest concerns of the communicator (Quiroz et al., 2021).

4.5 Ethical Research and Considerations

Ethical considerations apply to all research and the Australian National Statement on Ethical Conduct in Human Research states that ethical conduct is "more than do's and don'ts, it's about an ethos" that permeates the end-to-end research process (NHMRC, 2007 & 2023). Ethics also pertains to the value of the study to society and how the researcher maintains and exhibits ethical behaviour when research involves people, unequal power dynamics, commercial-in-confidence data and people in vulnerable settings. The following sections outline the ethical considerations pertaining to this research and how they were managed throughout the lifecycle of the study.

4.5.1 Ethical Considerations

This research was conducted in accordance with the general principles of responsible research as governed by the National Health and Medical Research Council (NHMRC, 2023) and outlined by (Bryman & Bell, 2014). During and following this research, the following ethical considerations were complied with:

- Research participants should not be subjected to harm in any ways whatsoever.
- Respect for the dignity of research participants should be prioritised.
- Full consent should be obtained from the participants prior to the study.
- The protection of the privacy of research participants had to be ensured.
- Adequate level of confidentiality of the research data should be ensured.
- Anonymity of individuals and organisations participating in the research had to be ensured.
- Any deception or exaggeration about the aims and objectives of the research had to be avoided.
- Affiliations in any forms, sources of funding, as well as any possible conflicts of interests had to be declared.
- Any type of communication in relation to the research should be done with honesty and transparency.
- Any type of misleading information, as well as representation of primary data findings in a biased way had to be avoided.

A number of these are discussed in more detail given their particular applicability to this study.

The ethics application was under consideration as the COVID-19 pandemic was unfolding. COVID-19 safety protocols and procedures and accepted formal ethical considerations were considered in the Human Ethics approval process through the University of Technology Sydney in accordance with NHMRC guidelines, with a number of additional requirements added for final approval. The study was approved with the reference ETH 19-4553.

4.5.2 Voluntary Participation and Protecting People from Harm

Protecting people from harm is a foundational concern for both health and social care researchers and aged care providers. Everyone was aware that their involvement was voluntary and that they could decline or withdraw their consent at any time. The study design involved two main data collection methods that could cause or be perceived to cause harm, namely, interviews and site visits in aged care environments. These methods required careful consideration at any time, but even more so in the midst of a pandemic. This was important for a number of reasons beyond what is usually considered to ensure that participants did not experience harm as a result of participating in the study.

4.5.3 Design of Participant Information and Consent Sheets

Conducting ethical research requires people to be informed, understand and consent to participation. Participant information and consent sheets were developed and reviewed by experienced research supervisors. Prior to commencement of any field work, ethical clearance was sought from the Human Research Ethics Committee of the University of Technology Sydney. The COVID-19 pandemic and ensuing Department of Health protocols and restrictions required additional consideration in the ethics application. These were incorporated into the ethical clearance processes prior to the commencement of the study.

4.5.4 Interviews

Power imbalances are seen as a major ethical consideration when conducting interviews, with the interviewer perceived to assume the power. This study focused on interviewing senior professionals, such as academics, chief executives and chief operating officers, a dynamic that could potentially offset the usual power imbalance and indeed be the reverse. All the interviews were conducted using Zoom, mitigating potential risk of

physical harm from exposure to COVID-19 should either the researcher or interviewee be COVID-19 positive.

4.5.5 Site Visits

A number of site visits were planned for this study. The importance of protecting the people in the aged care environment was paramount. With closed borders, Australia managed the early stages of the pandemic through public health orders preventing additional extraneous people from attending residential aged care homes. The need to protect people was uppermost in this researcher's mind, and when vaccination was available, this basic requirement was adhered to.

The researcher was also aware of the inherent professional and ethical obligations as a health practitioner when visiting sites, should sub-standard care or practice inconsistent with community expectations be witnessed. Should this occur, the researcher was aware of the accepted and immediate escalation pathways to the organisation and relevant external authorities and or regulator and how to adhere to these. During the study there were no instances where escalation was required.

4.5.6 Consent and Information Sheets

The NH&MRC guidelines state that fully informed consent should be voluntary and based on sufficient information and understanding provided prior to participating in research (NHMRC, 2023). Implicit in obtaining fully informed consent is transparency and an understanding of what the research is about, its value, what it involves, participants' rights and how they can escalate concerns should any arise. In addition, for this study, there was a heightened tension in the social services sector as a consequence of the RCACQS that was running concurrently for a significant part of the study. This required sensitivity to additional pressures on aged care providers and how the information they shared would be used and disseminated.

Participant Information Sheets and Consent Forms (PISC)

To this end, a series of "plain English" Participation Information Sheets and Consent Forms (PISCF) were reviewed and approved by the UTS HREC (Appendix 9.4). The PISCFs outlined the scope and intent of the study, the likely duration of the interview and recording of sessions. The PISCFs also contained information regarding how the data

would be stored and ultimately disseminated, who to contact with concerns about the study, a consent form and a revocation of consent should a participant decide they wished to withdraw from the study. The PISCFs were included in introductory emails when approaching potential participants. There were minor differences between the PISCs for both interview groups, as follows:

- Group 1: the scope outlined an interest in the models and success factors from the perspectives of the academics, thought leaders and developers.
- Group 2: the scope outlined that the interview would consider their perceptions regarding implementation.

In addition, there was an additional PISCF and consent sheet for those in the observational study, the researcher asked the CEO or nominee on behalf of the organisation for permission to review their website, to nominate a site for review and to inform the site of the visit. Again, the PISCFs outlined the scope and intent of the study, the likely duration of the interview and recording of sessions. The PISCF also outlined the duration and intent of the visit to the site. The PISCFs reiterated information regarding how the data would be stored and ultimately disseminated, who to contact with concerns about the study, a consent form and a revocation of consent should a participant decide they wished to withdraw from the study. The PISCFs were included in introductory emails when approaching potential participants.

Interviewees and local site managers were also informed of their rights during the research process. The PISCF outlined the potential benefits and risks of participating in the research and enabled the interviewees to fully appreciate and understand their involvement in the research. Participation of interviewees was voluntary, and they all provided written consent in accordance with the UTS HREC and NHMRC guidelines for ethical research.

Informed Consent

In addition to information sheets, informed consent requires acknowledging receipt and understanding of the information by either signing the consent form or providing verbal consent at the beginning of the interview. With COVID-19, the study PISCFs were included with the introductory email to participants. All participants either signed and

returned the PISCFs ahead of scheduling interviews or provided verbal consent at the commencement of the interview. At the commencement of each interview, consent was re-established, as required by the adapted processes for COVID-19. All the interviewees agreed to be recorded, which facilitated the interview and its transcription.

4.5.7 Confidentiality and Anonymity

The aged care community is highly interconnected in Australia and indeed internationally; maintaining confidentiality therefore posed potential challenges given the nature of the study. Some interviewees recommended or introduced their colleagues who they believed had important insights on the topic under investigation. In addition, the researcher was personally known to a number of the interviewees, which could be seen as a risk of bias and/or skewing the data. However, as a consequence of being interviewed by someone they knew and arguably trusted, interviewees may have provided more depth and detail because they were comfortable. The researcher was acutely aware of the need to regularly remind the participants that their responses were recorded, and provide assurances regarding confidentiality and data usage, storing and reporting.

Practical steps to maintain confidentiality throughout the process included detailing in the initial email invitation and request how interview recordings and transcripts would be stored, documented and reported and this was reiterated at the commencement of interviews. Practical assurances regarding anonymity in the outputs associated with this study were also provided. Throughout the interview transcriptions, pseudonyms were used to protect interviewees and providers. Providing these assurances to interviewees, and ensuring that all the research inputs, i.e., field notes, interviews and materials, would be deidentified, managed, stored, and used with the utmost confidentiality, was an important ethical measure. The interviews were also deidentified and allocated numbers, with an additional note as to whether they were national or international.

4.5.8 Data Management and Storage

This research conformed to the Australian Code for Responsible Conduct of Research (Code) (NHMRC, 2023) with regards to data management, i.e., access, storage and retention of the associated data. Following the completion of the five-year statutory

retention period, the primary data will be securely and confidentially disposed of in accordance with guidelines.

4.6 Methodological Reflexivity

In the opening sections of this chapter, I outlined my experiences in clinical governance in health and aged care, and the assumptions that I built through those experiences. Further to declaring my assumptions and to ensure that the research was conducted with integrity and was trustworthy, it was worth pausing to reflect on the ways this positionality shaped my research journey.

Positionality relates to the "position" from which one "chooses" to speak, from which the research aim is developed and the credibility of a study is established (Carpenter, 2010, p. 130). Coupled with this is the concept of reflexivity, a strategy that makes explicit the researcher's deep-seated views and judgments that influence and affect the research process (Carpenter, 2010, p. 131). While reflexivity in research is considered an integral consideration, especially qualitative research (Corlett & Mavin, 2018), it is less evident in mixed-methods research such as this, though acknowledged as having value (Cain et al., 2019). Day (2012) proposed a three-method approach to considering reflexivity in qualitative research:

1. the reflexive "thinking" of research
2. the reflexive "doing" of research, and
3. the "evaluation" of research.

I will step through how these three aspects of my positionality affected the ways in which this research was formulated, conducted and interpreted.

4.6.1 The "Thinking" of Research

First, reflexivity involves questioning our understanding of reality and the nature of knowledge and how alternative paradigms and perspectives can open up new ways of thinking about phenomena (Day, 2012). I outlined my motivations for undertaking this research in the Prologue and in Section 1.4. to understand if language and terminology influence the implementation of person-centred care models in residential aged care. Section 4.3 details how my pragmatic approach came from my professional experiences in health and aged care. I have also led several person-centred model implementation

processes across health and residential aged care. Consequently, my positionality could be considered as approaching the research with inherent bias in favour of person-centred approaches. I reflected on this critically and reflexively throughout the interviews and analysis, discussing these regularly with my supervisors, to minimise the potential bias, while also using my positionality as an advantage in how the research was conducted.

4.6.2 The "Doing" of Research

Second, reflexivity is about questioning our relationships with the research context, the research subjects/participants and the research data. The sampling and recruitment processes were outlined in section 4.4. I was aware of some of the interviewees professionally, through my networks and through aged care conferences and events, but I did not have a working relationship with them and I was introduced to them by people in my extended network through a snowballing approach. Snowballing is an accepted approach for interview recruitment, though it can elicit similar views. Every effort to account for this possibility was undertaken, such as conversation with my supervisors as the thematic analyses were undertaken. These introductions eventuated and were supported, I believe, by my positionality and regard as a trusted colleague, with a track record of implementing person-centred models. Further, as I discussed the aim of my research, others offered to help with introductions to people, stating that they saw benefit in the topic and the research more broadly. Consequently, they shared contact details and, in some cases, an introduction.

While I was grateful for these introductions, I was mindful that I was meeting new people for the first time. Virtual meetings present certain challenges for initial interactions, as body language and non-verbal behaviours are altered due to the medium. Additionally, for the Australian interviewees outside my circle, I was acutely aware of the added demands of Covid-19 and the Royal Commission; therefore, I was very sensitive to these additional demands on their professional responsibilities. I had some concerns that people might cancel their interview, which surprisingly did not occur. I was conscious of establishing rapport as I met people for the first time virtually, acknowledging the person who had introduced us, and sharing contextual information regarding how I knew of them.

In the opening moments of these interviews, I reflected on whether people would see the relevance of the research questions during their busy day, and how their role and background in finance related to person-centred models. After pleasantries, the generative question of what "person-centred care means to you" helped to open the conversation and the interview, revealing insights enabled by the semi-structured approach. I also had to challenge myself with regards to potential judgemental or stereotyping attitudes. To ameliorate any potential biases, following interviews, I journalled and reflected on these with my supervisors in our regular meetings.

4.6.3 The "Evaluation" of Research

Third, reflexivity involves questioning what is considered "valid" and valuable research. Research questions and interviews undertaken by trusted partners can elicit important information, as people share more with a trusted partner (Miller & Glassner, 2004, p. 130). My background in the sector, the trusted status I had and the timing against a backdrop of the Royal Commission were perhaps an advantage. While there was so much scrutiny, these interviews were perhaps seen by interviewees as an avenue to share their perspectives and reflect on the influence of the terminology and the legislative and regulatory aspects associated with aged-care delivery on the implementation of person-centred models of care for them. Indeed, interviewees regularly underscored how important they felt the information they were sharing was. Interviewees may have also regarded these interviews as a mechanism to provide an alternative perspective to the negative scrutiny and adverse media. I considered these aspects throughout the research journey, including my evaluation of the findings and results from this study. When opportunities arose, through conferences and other professional interactions, I was able to share some of these insights, thus giving credibility to the importance of the information shared and of the research itself.

4.7 Conclusion

This chapter has provided the methodology and methods used for the conduct of this explanatory sequential mixed methods design. It has also detailed the reflectivity and positionality of me as the researcher with regards to the research study and the interviewees. In Phase 1, the literature review highlighted gaps and findings. In Phase 2, the quantitative findings from the content analysis by Leximancer of the policy review

reports provided rich findings that informed the development of semi-structured guide. In Phase 3, the semi-structured interviews enabled me to explore the topics arising from Phases 1 and 2 and the research objectives. Semi-structured interviews provided the opportunity to explore diverse perspectives regarding the legislative pillars and the associated policy terminology as they sought to implement person-centred care models. Interview data, field notes post the interviews and transcript reviews added further richness to the quantitative data. These were analysed semantically and with a deductive approach, using themes. Finally, underscoring the use of an explanatory sequential design, the mixing of methods through integration enabled the development of meta-inferences. These meta-inferences were drawn from both thematic analysis and an abductive approach to the integrated data strands of the study enabling the conceptualisation of the research objectives. The following chapters will present the findings associated with each of these explanatory sequential phases.

SECTION 3 – FINDINGS

5. PHASE 1 – TERMINOLOGY IN POLICY, REVIEWS AND INQUIRIES

5.1 Introduction

> *"People may believe that in identity they will be healed, that in identity there is strength, but in identity there can only difference be, difference where we shut our hearts to love. Identity withers under intense gaze; it is hollow to the core"*
>
> (Grant, 2020, p. 89)

The previous chapters outlined the theoretical and methodological underpinnings of the approach taken to answering the research questions posed in this thesis. This chapter is Phase 1 of the explanatory sequential mixed-methods design and empirical work of this study and is the first of two about the findings in this research, namely, the results of a detailed analysis of the reports of Australian aged care reviews and inquiries that have influenced aged care policy from 2011 to 2021. Some notable reviews and inquiries have resulted in revisions or amendments to the core *Aged Care Act 1997* (Cth). The chapter commences with a contextual overview of reviews and inquiries into aged care and then

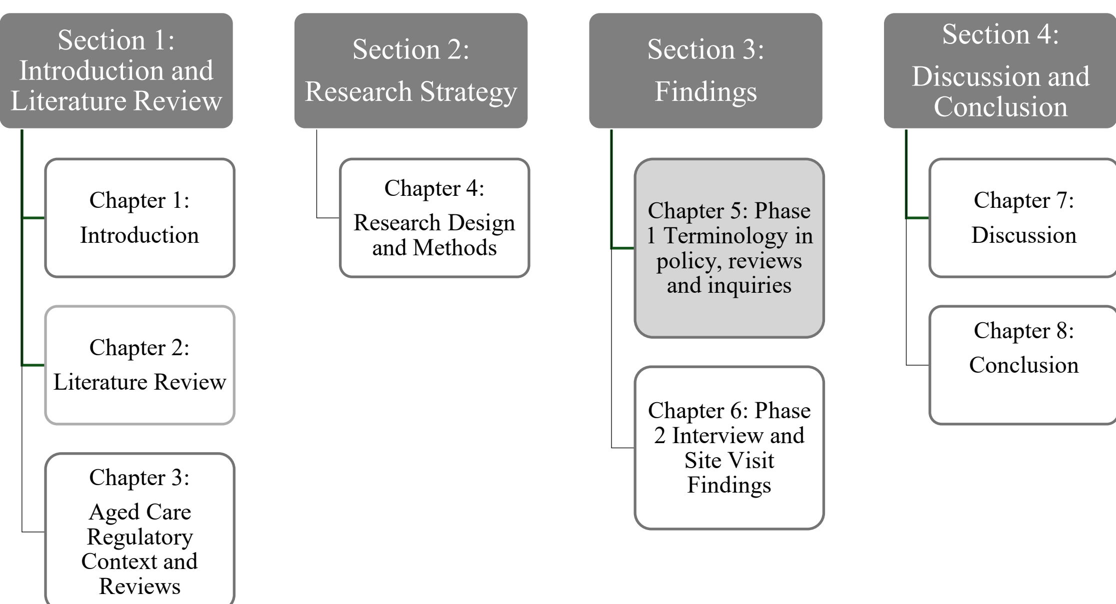


Figure 13 Thesis Outline Chapter 5

presents the analysis and findings of five reviews and inquiries that have shaped policy and aged care over between 2011 and 2021.

5.2 Australian Aged Care Reviews 2011-2021

As described in Chapter 3, the Australian aged care sector is governed by the *Aged Care Act 1997* (Cth). While some amendments have been made to the Act over the ensuing years, the major substantive change was *the Living Longer Living Better Act (LLLB) 2013* (Cth). While there are some overlaps with Chapter 3, this Chapter differs by providing nuance and the antecedents as to why the various reviews were conducted.

The decade spanning 2011 to 2021, as explored in this study of Australian aged care, was characterised by an extensive number of reviews. The decade was book-ended by two significant reviews, *The Caring for Older Australians* report of 2011 (Productivity Commission, 2011) conducted by the Productivity Commission, and the final reports of the Royal Commission into Aged Care Quality and Safety (RCACQS) in 2021. The RCACQS published three sets of reports: an interim report, *Neglect* (2019) (Royal Commission into Aged Care Quality and Safety, 2019b), *Aged Care and COVID-19: a special report* (2020) (Royal Commission into Aged Care Quality and Safety, 2020), and the final report, *Care, Dignity and Respect*, published in 2021 (Royal Commission into Aged Care Quality and Safety, 2021). For the purposes of this part of the study, the RCACQS *Neglect,* 2019, is the only report used for content analysis.

The first bookend, the *Caring for Older Australians (2011)* review (Productivity Commission, 2011), promoted a shift to consumer-centred approaches predicated on older Australians" choice and control. Key recommendations included development of a portal or website to provide information on the processes regarding access to the aged care system, and information on how to assess the quality of care available at each of the providers. Further, readily accessible information regarding the regulatory and complaints mechanisms was to be made available to consumers. The recommendations from this initial review were passed into law as an amendment to the *Aged Care Act* (1997). The recommendations and act also enshrined a statutory review clause. Ensuing reviews until 2017 focused on two main themes, sector financial sustainability associated with the twin concerns of increasing demand and rising cost of delivery, and the implementation of the recommendations as per the statutory clause mentioned above.

The second bookend was the RCACQS (2021), the antecedents of which began with a major quality and safety scandal in South Australia. In reviewing this state scandal, Professor Aaron Groves, the SA Chief Psychiatrist, identified dehumanising care practices, in the Makk and McLeay homes at the Oakden Campus, despite the service being deemed fully accredited (Groves et al., 2017). The *Oakden Report* (2017) highlighted governance, culture, clinical and practice failures associated with the Oakden Older Persons Mental Health Campus. The resulting media revealed that the issues associated with Oakden were not isolated (Connelly et al., 2018; Donnellan, 2018; Donnellan & Gage, 2017; Morton, 2019). Following sustained media interest, whistleblowers and complaints, the RCACQS was called by Prime Minister Scott Morrison. The final 10-volume report, *Care, Dignity and Respect, 2021,* from the evidence received over three years of hearings, was handed to General David Hurley, the Governor-General of Australia in 2021.

The focus for this thesis was to understand the terminology used in the key reviews and responses over the decade of 2011 to 2021 and how this terminology may have impacted on aged care provider and practice settings.

The next section of this chapter outlines the findings from the analysis undertaken to examine the reports and reviews. The number of reports and reviews initiated by the Australian Government since the *Aged Care Act 1997* (Cth) have been extensive; therefore, this chapter focuses on a purposive sample of those reviews from 2011 to 2021 that shaped the sector and underpinned this study. The reports considered were those that were most relevant to the research questions and the reports included were those that were initiated by the Australian Government, were inquiries or reviews that generated reports that were freely available, and had been informed by submissions, evidence and public consultation. Reviews that focused on financing and workforce were excluded from the analysis presented in this chapter, as this study concentrated on reports influencing the broader aged care sector to promote choice and control for older Australians.

In parallel with this study, the RCACQS conducted a comprehensive analysis of all the reports of reviews as directed by their terms of reference. By virtue of their powers, the commissioners subpoenaed all the previous aged care reviews, investigations and recommendations since the *Aged Care Act 1997* (Cth) was introduced in Australia.

Further, they subpoenaed the minutes of the Federal Government's Cabinet meetings, including those deemed to be "Cabinet-in-confidence" and meeting minutes from the Department of Health and Ageing. These reports were analysed by the Royal Commission, mostly through a forensic or legal lens (Ireton, 2023; Prasser & Tracey, 2014). In particular, the Royal Commission focused on the implementation, or more importantly, the non- or partial implementation, of those recommendations from previous inquiries. During the RCACQS, personnel from the Department of Health were asked to give evidence regarding the status of implementation of the recommendations in their testimonies.

5.2.1 Content Analysis of Aged Care Reports and Reviews

This quantitative component of the explanatory sequential mixed-methods design employed content analysis, which was described in Chapter 4:4.1. Content analysis can be done in various ways, from simply counting key words to using advanced data mining software. The capabilities and specificity of data mining software have increased exponentially in recent years, driven by the growing volume of available data. This study used both simple search-and-counting of key terms and the power of Leximancer, brief descriptions of both will follow in the next section.

In the next section, I describe the word frequency of key terms identified in the literature review, such as "consumer", "customer", "client" and "care recipient". The second stage of this phase used Leximancer to analyse the five selected reports that shaped the decade 2011-2021 then follows.

5.2.2 Word Frequency Analysis

Analysis of words identified by a simple search of all the reports post the *Aged Care Act, 1997* (Cth) determined how each report referred to people who received aged care services, the number of times various words and terms, such as "care recipient", "resident", "consumer" and "client", were used and whether the use of these words had changed in frequency since the *Aged Care Act 1997* (Cth) became law**.**

The following two figures, **Figure 14** Frequency of Terms Used to Refer to People Receiving Aged Care Services, in Aged Care Reviews and Responses Between 1997 and 2020 and **Figure 15** Time Series of Words - Terms Used to Refer to People Receiving

Aged Care Services, in Aged Care Reviews and Responses Between 1997 and 2020), illustrate the change in frequency of use of these terms over time, noting that after the Productivity Commission report, *Caring for Older Australians" Report (2011*), the terms used more frequently were terms associated with market and economics. The term "consumer" was cited 336 times in 2011 while four years later, in the *Legislated Review of Aged Care* (Tune Review), *2017*, it was mentioned 776 times. Interestingly, the term "consumer" is not used in the *Aged Care Act 1987* (Cth); rather "care recipient" was the term used to refer to people, "to whom care was delivered". These terms and the changing language were occurring under governments of both major political persuasions, the Australian Labor Party (ALP) and Liberal National Party (LNP).

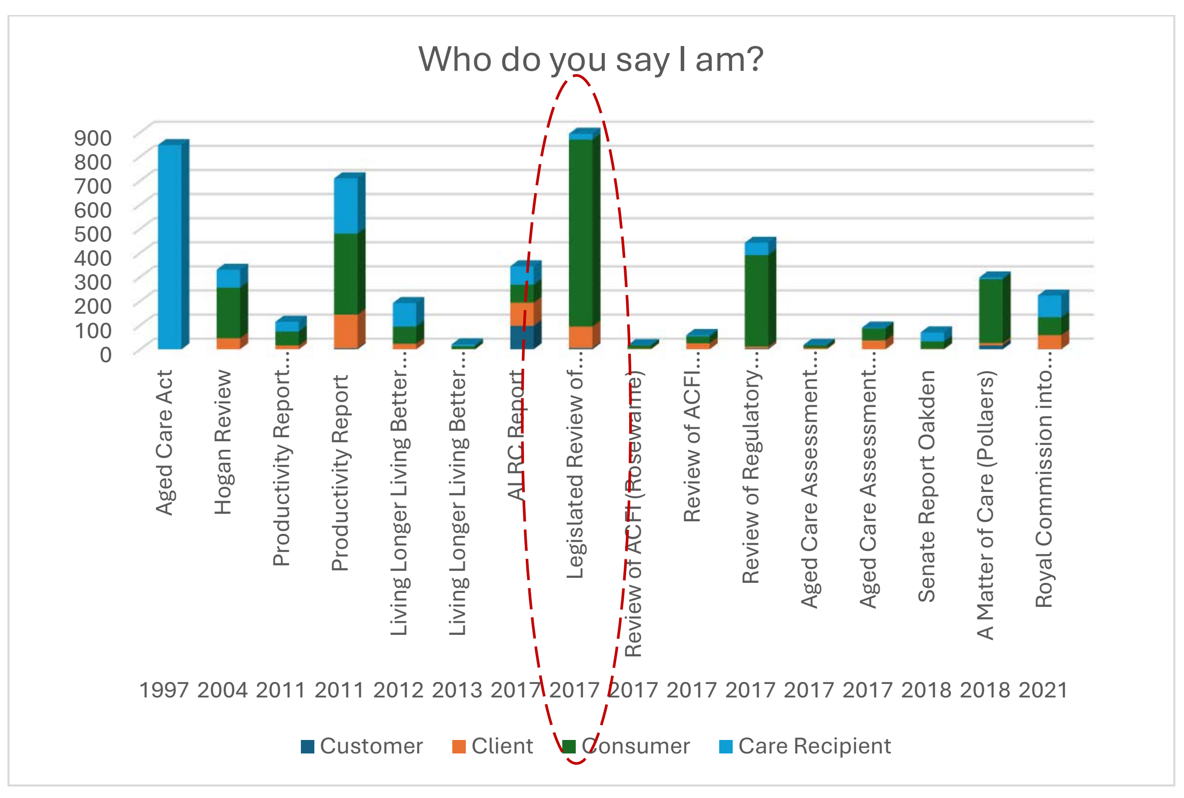


Figure 14 Frequency of Terms Used to Refer to People Receiving Aged Care Services, in Aged Care Reviews and Responses Between 1997 and 2020

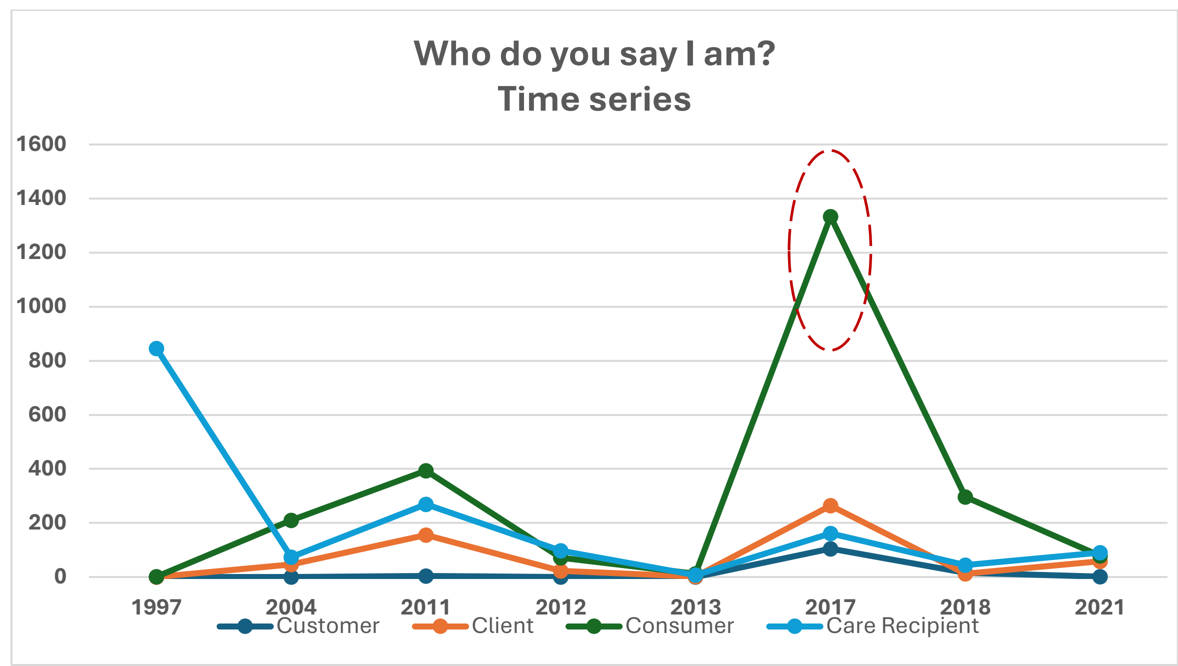


Figure 15 Time Series of Words - Terms Used to Refer to People Receiving Aged Care Services, in Aged Care Reviews and Responses Between 1997 and 2020

Figure 15 Time Series of Words - Terms Used to Refer to People Receiving Aged Care Services, in Aged Care Reviews and Responses Between 1997 and 2020, demonstrate that use of the term "care recipient" decreased in frequency in reviews and reports over the 20-year period with shifting government policy and concerns regarding fiscal sustainability. Both graphs demonstrate that the frequency of "consumer" increased from 2011 and peaked in 2017. The term "consumer" was also most obvious in the *Legislative Review of Aged Care* (Tune, 2017).

The following section describes the second stage of this phase, using Leximancer for more detailed analysis of a purposive sample of reports.

5.2.3 Concept Analysis of Reviews and Reports with Leximancer

Reflection on these high-level findings prompted the second stage of analysis in this phase of the study, namely, concept analysis, using Leximancer. As mentioned in Chapter 4 section 4, Leximancer can analyse the content of collections of textual documents and display the extracted information graphically. The information is displayed by means of a conceptual map that provides a bird's eye view of the material, representing the main concepts contained within the text as well as information about how they are related

(Leximancer, 2021). Leximancer represents concepts in two ways: graphically, in the form of a concept map, and as a ranked list. A Leximancer concept map represents the concepts and themes in the data as dots of varying sizes (and colours). The size of the dots represents the importance of the concept (more prominent concepts appear as bigger dots or circles on the map) and the degree to which concepts are connected with other concepts. The larger the concept dot, the more connected it is with other concepts in the data. The relationship between concepts is represented by their position on the map (the closer the concepts appear on the map, the stronger the relationship between them). Concepts that are highly connected are joined by lines (Engstrom et al., 2022; Leximancer, 2021).

In addition to concept maps, Leximancer presents concepts and themes in the form of interactive “ranked lists of concepts” that are provided in tables. These interactive lists enable further analysis and understanding of the concepts and the blocks of text from which the concept was coded, by clicking on a concept related to the study. These tables are available as CSV files to download for further analysis. The ranking of concepts is calculated based on the relationship between concepts (relevance) and frequency (how many times the concept appears). Relevance is presented through percentages. So, for example, the top ranked concept almost always has a relevance rating of 100%, which means it is the most frequently occurring concept in the text. “Other Relative Percents are calculated by dividing a concept’s count into the top occurring (100% relevance) concept’s count” (Leximancer, 2021). What this list provides is the ability to see the concepts as a percentage of the total. Leximancer also provides other scores such as co-occurrence and prominence scores which measure frequency and connectivity of concepts.

Collectively, these Leximancer features provided a means to both quantify and display the conceptual structure of the reports from the reviews and inquiries in government policy documents, which enabled deeper insights through the interactive visualisations and features. The outputs associated with each of the five reviews (see Figures 16, 17 18, 19, 20, 21, 22, 23, 24, 25, 26 and 27) are Leximancer-generated maps and lists of the concepts from the analysis of each report which emerged. As noted above, themes are represented in larger circles, which are a collection of related concepts; with concepts represented as dots in a theme which is depicted as a circle. The proximity of dots

represents the strength of the relationship between the concepts. In addition, there are tables attached which provide a numerical count of these concepts in the themes. Included in the table below is a reference guide of these Leximancer terms and features and their definitions to assist with the outputs that follow, as derived from the Leximancer handbook (Leximancer, 2021).

Table 18 Definitions for Leximancer Outputs and Terms

Term	Definition
Concept maps	• The concept map is divided into two sections: a visual display of concepts and their relationships to each other on the left and report tabs on the right for interacting with the concept map.
Ranked concept lists	• Display concepts ranked by their frequency of occurrence in the text. • These are displayed in two lists, name-like (proper nouns) and word-like (ordinary words).
Themes	• Themes are the coloured circles that group clusters of concepts. • Concepts that appear together (often in the same pieces of text) attract one another strongly and so tend to settle near one another in the map space. The concepts are clustered into higher-level themes when the map is generated.
Concept seeds	• Concept seeds represent the starting point for the definition of concepts.
Concepts	• Concepts in Leximancer are collections of words that generally travel together throughout the text. • Concepts are collections of correlated words that encompass a central theme. • Concepts written with an upper case first letter represent name-like (proper noun) concepts.
Hits	• The hits column denotes the number of text blocks in the project associated with the theme

Term	Definition
Name-like	• Name-like concepts represent concepts that are proper nouns
Word-like	• Word-like concepts are concepts that appear in lower case
Thesaurus	• Thesaurus is the culmination of Leximancer learning relevant to seeds and concepts.
Co-occurrence score	• One of the principal aims of Leximancer is to quantify the relationship between concepts (i.e., the co-occurrence of concepts), and to represent this information in a useful manner (in a concept map and lists)
Prominence score	• The prominence score combines the strength and frequency scores using Bayesian statistics. • Prominence scores are absolute measures of correlation between category and attribute and can be used to make comparisons over time.

The findings of each review analysis is presented and discussed separately. What follows are the individual review or inquiry reports. For clarity, I refer to all documents associated with reviews and inquiries for the period 2011-2021 as "reports" when presenting their Leximancer outputs and commentary.

Each report had a series of Leximancer-generated outputs as follows:

- Concept map
- Table of prominent themes, concepts, co-occurring concepts and thesaurus-identified words, and
- Screen shot or table of the ranked order of concepts.

The Leximancer analysis of a purposive sample of reports over the decade 2011-2021 for concepts, themes and sentiment associated helped answer the first research question: "What are the key language and terminology shifts in aged care policy reviews?" The reports analysed for this study are listed in **Table 19** Reports and Inquiries Reviewed.

The purposive sample of reports fell into two categories; the first three reports relate to a government-supported review, *Caring for Older Australians 2011* (Productivity Commission, 2011), which ultimately informed a new Act and direction for the aged care

sector. The new direction was further supported by a government-appointed sector committee to help with the implementation of the new policy direction, based on its report *The Aged Care Roadmap* 2016, (Tune, 2016). Associated with the legislation and binding aspects of the Aged Care (*Living Longer Living Better) 2013 Act*, (Cth) a legislative review was required and commissioned with a government-appointed reviewer. This resulted in the *Legislative Review of Aged Care 2017* (Tune, 2017), the author of which was also the chair of the aforementioned aged care sector committee.

The final two reviews fell into the category of commissioned reviews as a result to perceived failures. The first review, *Review of National Aged Care Quality Regulatory Process* (Carnell & Paterson, 2017) was under the auspices of the Federal Government. The second review took place under the auspices of the Governor-General, which afforded it greater investigative and statutory powers, including the power to compel witnesses to appear and to subpoena documents, as described in Chapter 3 (Royal Commission into Aged Care Quality and Safety, 2019b).

While the RCACQS produced three major reports, only its first report *Neglect* (Royal Commission into Aged Care Quality and Safety, 2019b) had been published when this research phase was taking place and hence is the only report analysed here. Each of the reports will now be presented in turn, including background to the reports, and the Leximancer outputs and analysis following the model of Hepworth and Paxton (Engstrom et al., 2022; Hepworth & Paxton, 2007; Travaglia & Braithwaite, 2009).

Table 19 Reports and Inquiries Reviewed

Report	Year	Author/s	Commissioner
Caring for Older Australians	2011	Productivity Commission Inquiry	Department of Health and Aged Care
Aged Care Roadmap	2016	Aged Care Sector Committee	Department of Health and Aged Care
Legislated Review of Aged Care	2017	Tune	Department of Health and Aged Care
Review of National Aged Care Quality Regulatory Processes	2017	Carnell Patterson	Department of Health and Aged Care
Royal Commission into Aged Care Quality and Safety -Interim Report - Neglect	October 2019	Hon. Richard Tracey AM, RFD, QC (deceased) and Ms Lynelle Briggs AO	Royal Commission into Aged Care Quality and Safety

5.3 Document 1: *Caring for Older Australians* Report, Productivity Commission 2011

5.3.1 Background and Context to the Report

In 2007 there was a significant change of government. After almost 12 years of Liberal and Nationals in power, the Labor party was elected with a large reform mandate and a sizeable majority. This new Labor Government initiated a number of reviews across the wider health economy, which culminated in the *Health and Hospitals Reform Report (2009)* (Bennett, 2009*)*. In 2010, the Gillard Government referred the aged care system to the Productivity Commission (PC) (Woods & Gilchrist, 2020), which received more than 900 submissions to both its draft and final reports (Hughes, 2011). The final report (Productivity Commission, 2011) enjoyed bipartisan support for its recommendations, although the Minister for Mental Health and Ageing, Mark Butler, engaged in further consultations with the general public to assist with the overarching government response (Butler, 2013, 2015; Hughes, 2011).

The key objective posed to the Productivity Commission was *"*to develop detailed options for redesigning Australia's aged care system to ensure it can meet the challenges facing it in the coming decades" (Productivity Commission, 2011, p. 5). In its terms of reference (Productivity Commission, 2011, p. v.), the Commission was required to:

1. Systematically examine the social, clinical and institutional aspects of aged care in Australia, building on the substantial base of existing reviews into this sector.
2. Develop regulatory and funding options for residential and community aged care (including services currently delivered under the home and community care program for older people).
3. Systematically examine the future workforce requirements of the aged care sector, taking into account factors influencing both the supply of and demand for the aged care workforce, and develop options to ensure that the sector has access to a sufficient and appropriately trained workforce.
4. Recommend a path for transitioning from the current regulatory arrangements to a new system that ensures continuity of care and allows the sector time to adjust. In developing the transitional arrangements, the Commission should take into account the Government's medium term fiscal strategy.

5. Examine whether the regulation of retirement specific living options, including out - of-home services, retirement villages such as independent living units and serviced apartments should be aligned more closely with the rest of the aged care sector, and if so, how this should be achieved.
6. Assess the medium and long-term fiscal implications of any change in aged care roles and responsibilities.

The report provided a blueprint for a comprehensive overhaul of aged care to create a system that could deliver high-quality, accessible services while remaining financially sustainable for the future decades. Because of the recommendations associated with the report, the Australian Government enacted what were referred to as the *Living Longer Living Better reforms in the Aged Care (Living Longer Living Better) Act, 2013* (Cth), as outlined in Chapter 3. Collectively, these reforms instituted the term “consumer” and promoted “choice” for older Australians with regards to service delivery options.

The descriptions of the review and inquiry reports that follow include a series of outputs generated by Leximancer from the algorithms and processes in the program. These outputs are:

- Concept map,
- Table of prominent themes, concepts, co-occurring concepts and thesaurus-identified words, and
- Screen shot or table of the ranked order of concepts.

5.3.2 Leximancer Analysis and Outputs

Concept Maps

Figure 16 Leximancer Concept Map for *The Caring for Older Australians Report* (2011) below shows a Leximancer-generated concept map for the *Caring for Older Australians* report 2011, (Productivity Commission, 2011). As described in Chapter 4, the concept map is a graphic display of the information contained from the matrix of co-occurrence between the concepts. Immediately visible are the themes in the report, these are depicted as large circles, and are colour coded, (heat mapped), red is always the most dominant theme in a report, in this case the theme of ***care***. The central position of the red theme in

all the reports indicates the significance of the theme in the report. Themes, depicted as circles, contain a series of words represented as dots or words which collectively are related to the theme. These dots and words are concepts that Leximancer has learnt through its automation processes, screen shot of ranked order of concepts. The larger the dot and closer the dots are in the map relates to the frequency of in the report.

Ranked Concept Table

Table 20 provides the ranked list of concepts generated by Leximancer. These are the same concepts as those on the map; the table provides additional information as to the importance of each concept in relation to the others. The concepts' related counts and relevance scores contribute to the theme (circles) and are included to demonstrate how the themes are constituted and how the concepts travel together throughout the document. *care* is the number one ranking concept, with a relative count of 100%. A relative count of 100% means that all other concepts that appear in the *Caring for Older Australians* report (Productivity Commission, 2011) have some conceptual relationship to the concept of *care*. The absolute count of 4103 in the case of the concept of *care* refers to the number of times that *care* appears in the *Caring for Older Australians, 2011* document *(Productivity Commission, 2011)*. These ranked concepts are also colour coded to reflect their position in the concept map. A screen shot from the Leximancer program is included below the top 20 concepts from the report.

Table 21 provides the same information in a table format derived from all the interactive features of Leximancer. This table includes the theme, the Concept, the relative counts, and relevance percentages as generated by Leximancer. Again, as described in Chapter 4, Leximancer concepts and co-occurring concepts, are derived from learning and coding (based on the algorithms in the program) in two sentence blocks of text in the report. From learning the report Leximancer automatically generates "***themes***" related to "*concepts*" and records these as a "hits" number, which refers to the number of text blocks associated with the theme. Concepts are represented on the map as dots. Concepts are not directly equivalent to words: the concept "*people*" for example, might include the concepts *older, life, age,* and *home* (see Chapter 5, Table 21). "***Themes***", depicted as circles, are a collection of related "*concepts*". The closer concepts are co-located on the map, the stronger the association between the concepts (see Chapter 4, Section 4.1). To differentiate between themes and concepts in the narrative of the reports, themes will be

formatted in bold italics e.g. ***Care*** and concepts and thesaurus words in lower case italics e.g. *care*. In terms of tagging and referencing quotes, Leximancer automatically generates a reference tag or link to the document, these references are used throughout this chapter.

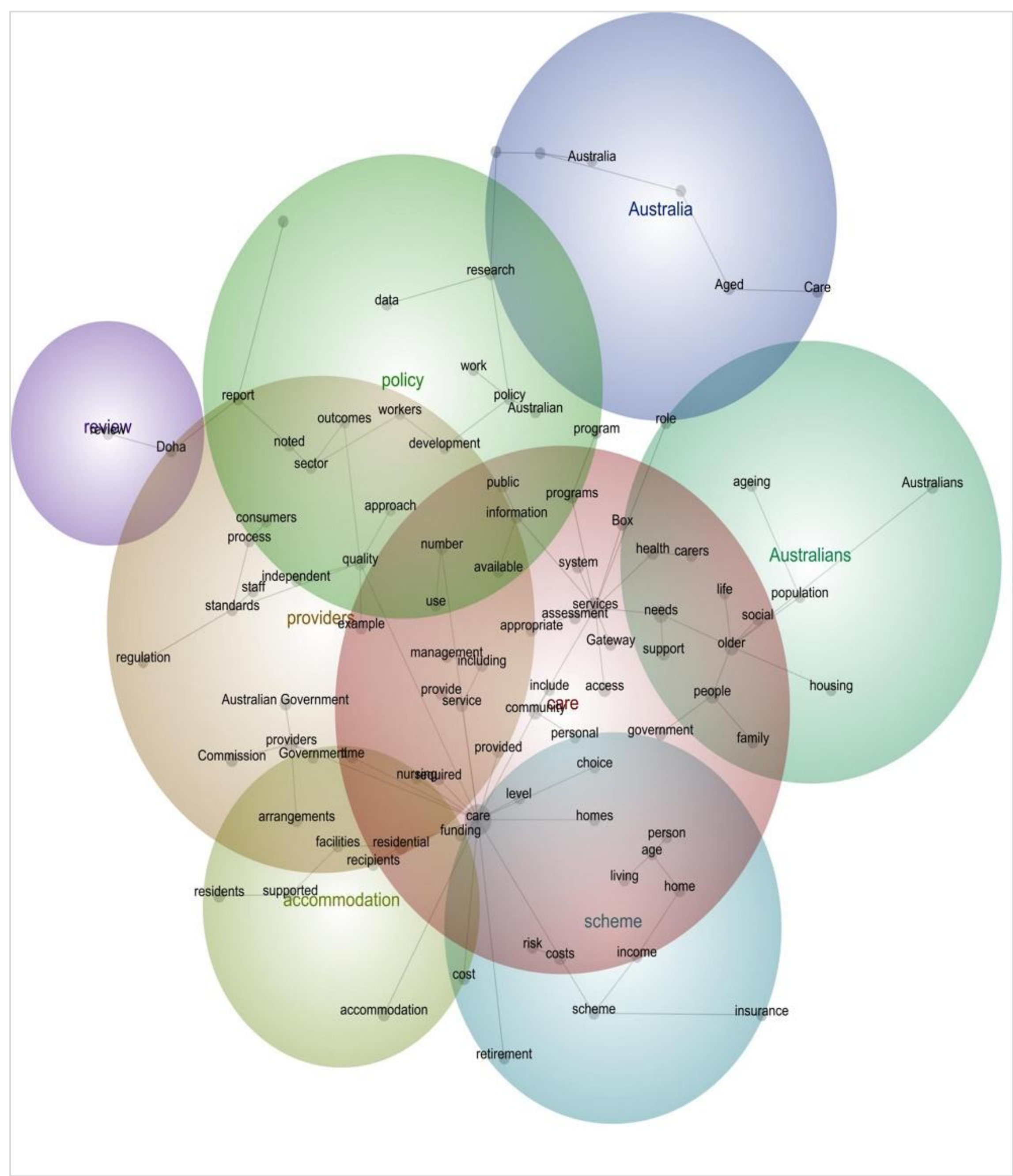
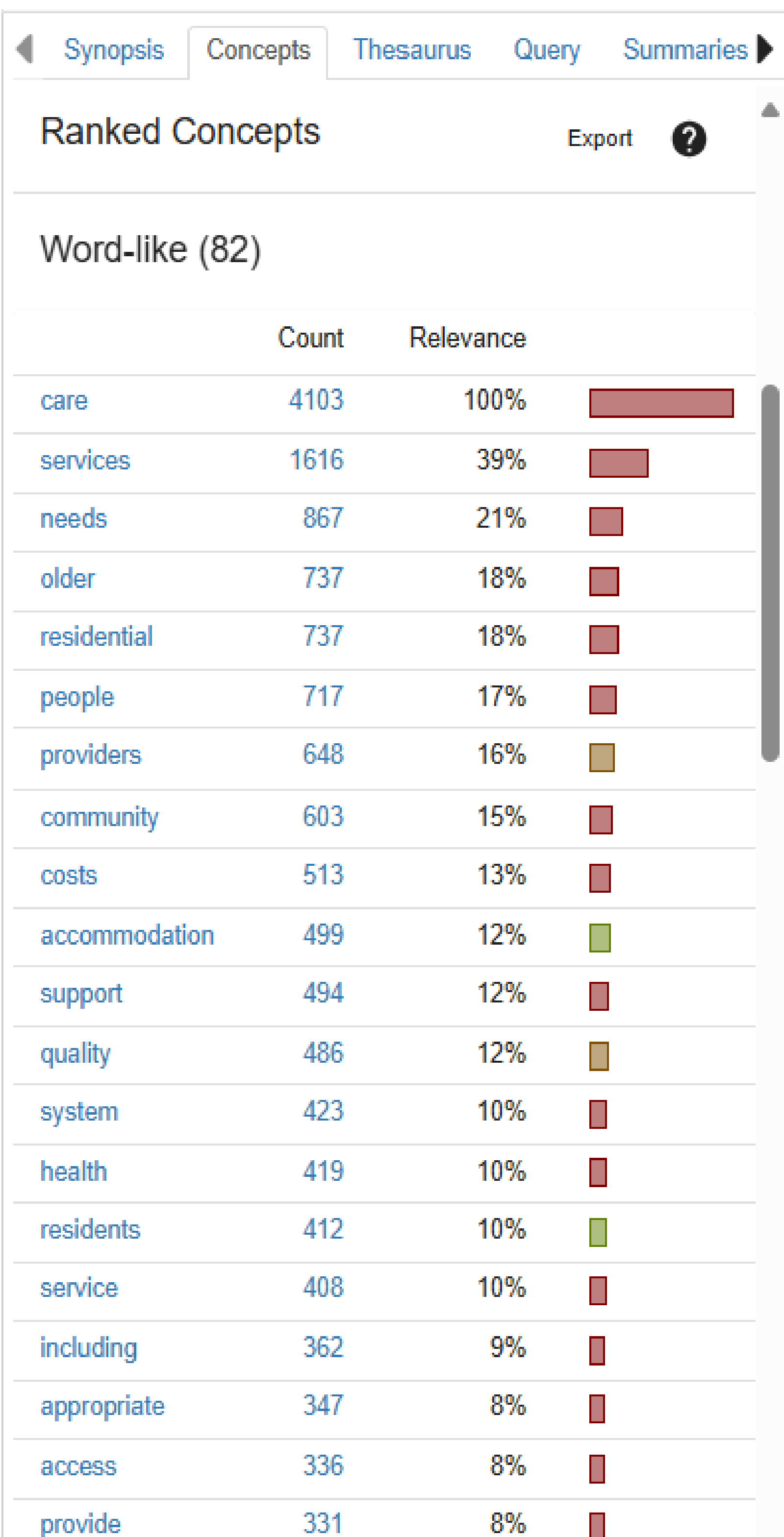


Figure 16 Leximancer Concept Map for *The Caring for Older Australians Report* (2011)

Table 20 Ranked Table of Concepts in The *Caring for Older Australians Report* (2011)

Concepts	Word	Count	Relevance %
care	Word	4103	100
services	Word	1616	36
needs	Word	867	21
older	Word	737	18
residential	Word	737	18
people	Word	717	17
providers	Word	648	16
community	Word	603	15
costs	Word	513	13
accommodation	Word	499	12
support	Word	494	12
quality	Word	486	12
system	Word	423	10
health	Word	419	10
residents	Word	412	10
service	Word	408	10
including	Word	362	9
appropriate	Word	347	8
access	Word	336	8
provide	Word	331	8



	Count	Relevance
care	4103	100%
services	1616	39%
needs	867	21%
older	737	18%
residential	737	18%
people	717	17%
providers	648	16%
community	603	15%
costs	513	13%
accommodation	499	12%
support	494	12%
quality	486	12%
system	423	10%
health	419	10%
residents	412	10%
service	408	10%
including	362	9%
appropriate	347	8%
access	336	8%
provide	331	8%

Figure 17 Rank Order of Concepts in *Caring for Older Australians* Report (2011)

Table 21 Themes, Concepts, Co-Occurring Concepts and Thesaurus Words Associated with The *Caring for Older Australians Report* (2011).

Theme	Concept	Count	Relevance	Co-occurring concepts	Thesaurus-identified words
Care Hits: 4593	Care	4103	100	management, assessment, personal, living, support	aged, recipients, co-contribution, palliative
	Services	1616	39	access, support, provided, assessment	services, hubs, translation, human
	Needs	867	21	assessment, access, older, people, appropriate	needs, reassessment, clients, special
	Older	737	18	people, housing, access, carers, social, needs, living, life, person	older, stress, reluctant, self-funded, resilience
	Residential	737	18	facilities, community, homes, accommodation, residents, nursing	residential, visiting, rebate
	People	717	17	older, life, age, homes, living, housing, needs	disabilities, impairments, gay, morbidities
	Community	603	15	residential, support, family, services, living	community, matched, generalist, approvals
	Support	494	12	carers, assessment, programs, family, older, person	carer, comfort
	Costs	513	13	insurance, scheme, risk, income	predictable, catastrophic
	System	423	10	choice, consumers, assessment, information	choice, consumer, scarcity, rationing
Providers 2208 hits	Providers	648	16	consumer, recipients, service, supported, accommodation	negotiate, simpler, tailor, bank, liquidity

Theme	Concept	Count	Relevance	Co-occurring concepts	Thesaurus-identified words
	Quality	486	12	outcomes, standards, life, information	assurance, committee, insights, unsafe, indicators, perceptions
	Commission	428	10	Independent, report, regulation, supported	Considers, proposes, notes, envisages
	Number	275	7	programs, choice, workers, population, residential, nursing	overlap, ghetto, analysts, imported
	Australian government	270	7	standards, funding, include, programs, process, supported, regulation	complied, audited, reviewing, friendship
	Time	212	5	staff. review, life, facilities, residents, standards, person	hoists, in-room frame, consuming, completing
	Management	166	4	include, staff, development, assessment, outcomes	pain, wound, hydration, rehabilitative, ulcers
	Standards	194	5	quality, outcomes, regulation, process, review	standards, complied, audited, perceptions
Accommodation 1556 hits	Accommodation	499	12	supported, income, living, residents	accommodation, repayment, discount
	Residents	412	10	supported, facilities, accommodation	resident, tradeable, tendering, concessional

Theme	Concept	Count	Relevance	Co-occurring concepts	Thesaurus-identified words
	Cost	291	7	costs, accommodation, income, personal, recipients, risk, government	cost
	Arrangements	283	7	funding, regulation, approach, recipients, policy	harmonising, simplifying, cashing, supply-side
	Recipients	254	6	outcomes, income, providers, quality, required	wealthier, indifferent, pick, upgraded
	Facilities	232	6	residential, residents, homes, supported	visiting, rebate
	Supported	226	6	accommodation, living, personal, recipients	supported, obligation, trading, quota, tendering
Australians 654 hits	Australians	654	16	older, housing, access, carers, homes, age	older, caring, negotiation, proficient
Australia 172 Hits	Australia	172	4	ageing, number, research, social,	Royal College, Curtin University, Lutheran
Policy 161 hits	policy	161	8	research, data, development, program, regulation,	policy, makers, ceasing, rethink
Review 136 hits	review	136	3	independent, process, standards, outcomes, time	review, reviewing, meta-analysis
Insurance 122 hits	Insurance	122	3	scheme, risk, population, social, costs, funding	insure, pre-funded, collective, user-pays

5.3.3 Narrative Description of the Leximancer Outputs

There are eight themes visible in the concept map, (**Figure 16**) all of which are closely connected and indeed overlapping indicating a high degree of association. The themes appear to reflect the remit of the report, the name of the report and the associated recommendations. The themes are ***care*** (4593 hits), ***provider*** (2208 hits), ***accommodation*** (1556 hits), ***Australians*** (654 hits), ***Australia*** (172 hits), ***policy*** (161 hits), ***review*** (161 hits) and ***insurance*** (122 hits). These are all listed in the left-hand column of **Table 20**.

Care is the largest theme, though interestingly the ***provider, policy*** and ***accommodation*** themes are tightly connected to it. That the ***provider*** theme ranked second was a surprise. To the top right of the ***care*** theme is the theme ***Australians***, reflecting both the remit and title of the report. The ***insurance*** theme is the smallest and offset to the bottom right of the map. A closer examination of the themes and concepts in both these outputs helped expose the report's narrative.

When the ***care*** theme (red circle) is reviewed, the concepts from which it was constituted by Leximancer are *care*, *services*, *older*, *residential*, *people*, *community*, *support*, *system* and *resident*. The three largest dots in the ***care*** theme visible in the concept map are the concepts of *care, services* and *needs*. To build this theme, Leximancer identified further the concepts of *aged, recipients, access*, and *support,* (these terms are derived from the algorithms within Leximancer as it learns the text through its processing steps). The PC report concluded that for older Australians, a model of care should be tailored to people's needs, encompassing the concepts of *care, service and needs*, as indicated in the quote captured by Leximancer:

> A model of care and support based on flexible service entitlements which are tailored to people's needs, rather than on providers funded for approved places and packages, will significantly enhance the delivery of continuous care. – The care entitlements should comprise elements of personal and specialised care that meet the changing needs of individual older Australians together with carer support services. (/PC report 2.pdf/PC report 2~10.html 1_2296)

Supporting the model of care quote, with a count of 423 was the concept of *system*, whose co-occurring concepts and thesaurus words were the concepts of *choice, consumers, assessment, information, scarcity and rationing*, all in the ***care*** theme. A nuanced analysis of these concepts appears to point to evidence heard regarding an aged care system that was fragmented and difficult to navigate, reflected in this quote captured with these concepts:

> Carers said that the aged care system is complex, difficult to navigate and carer support is currently administered in an ad hoc way across a number of programs and jurisdictions (/PC report 2.pdf/PC report 2~26.html 1_5831)

Indeed, using the interactive aspects of Leximancer to drill further into the concept of *consumer* revealed other co-occurrence concepts associated with *consumer*, such as *information*, *choice*, *provider* and *risk*. Further, these concepts aligned with the central aspects of the recommendations, namely, wider choice and more information for consumers. These were central to the report from the submissions received and the explicit request from older Australians who wanted to be able to choose their service provider.

From the evidence received, the commissioners believed that timely, accessible information would enable consumer/aged care recipients greater choice about the services and providers to support them, as demonstrated in this quote:

> Consumers will be able to exercise greater choice about who provides services, (/PC report 2.pdf/PC report 2~16.html 1_3632).

The ensuing recommendations in the final report linked to the concepts of *consumer* and *choice* were references to what this would mean in practice, which the report’s authors defined as:

> An approach to care that allows people to have greater choice and control over the care and support services they receive, to the extent that they are capable and wish to do so. (/Productivity Report.pdf/Productivity Report~1.html 1_111)

There was an acknowledgement that the shift to *consumer* and *choice* was not atypical in other social service sectors.

> In a number of other areas of social policy there is a move away from traditional service-centred arrangements where providers and government officials decide what is best for care recipients towards giving people more choice and control. As discussed, older Australian generally value the opportunity to make choices about things that are important to them. (/PC report 2.pdf/PC report 2~12.html 1_2774)

To achieve these aims there was the observed need for more information to support decision-making for older people and their families and in how to navigate the aged care system. To respond to this need, it was proposed to create a "Seniors Gateway" (online portal) to facilitate choice for people researching ongoing support (Recommendation 9.1 p149). Based on the evidence heard by the commissioners, this "Seniors Gateway" was to centralise and streamline information and access.

The ***provider*** theme, which overlapped with the ***care*** theme, was primarily characterised by concepts related to the organisational aspects of service provision, including management practices and a provider-government dynamic. These themes overlapped with the concepts of *provider, quality, commission, the Australian Government, time, management and standards*, as is evident in the concept map and in the table.

Leximancer identified concept co-occurrences of alternative terms to refer to people, *consumers* and *recipients*. For *quality*, the second largest concept in the ***provider*** theme, it revealed the co-occurring concepts of *outcomes, standards and information* and the thesaurus-identified words of *assurance, insights*, *indicators and perceptions*. The focus on quality service provision was represented in the third largest concept, which was a recommendation for a quality commission. The Leximancer co-occurring concepts related to *commission* were *independent*, *reports, regulation* and *supported*. Interestingly, the report documented some negative opinions regarding the utility of regulation and reporting processes, the PC report comments that there is a perception that there was a need to reduce regulatory reporting,

> reporting requirements are overly burdensome and duplicative, consuming management and staff time which could be better directed towards providing care services /Productivity Report.pdf/Productivity Report~7.html 1_1342.

Furthermore, the PC report states that these reporting aspects were perceived as costly;

> the extent of some mandatory disclosure requirements to consumers impose unnecessary costs on providers” /Productivity Report.pdf/Productivity Report~7.html 1_1348.

These concepts and their relationships suggest the reports focus on the interrelationships of government, provider and older people with regards to the delivery and experience of care services with appropriate quality considerations.

Highlighting Leximancer’s ability to identify concepts was the concept *ghetto* in the thesaurus, the relationship of *ghetto* to the concept *number* and the co-occurrence concepts of *programs*, *choice*, *population* and *residential*. Using the inbuilt features to understand this concept in the context of the document. The context relates to whether the Government formulae and ratios for regions would be tradeable or exchanged between providers, as reflected in these quotes:

> The Commission proposed in the draft report that facilities should be able to trade their supported resident ratio obligation with others in the same region so that facilities could provide more or fewer supported resident places in line with their preferred service model approach. (/PC report 2.pdf/PC report 2~5.html 1_1100)

Leximancer further revealed:

> A common concern was that it would result in “ghettos” developing… if they were tradeable — and particularly in large regions where trades are made. (/PC report 2.pdf/PC report 2~5.html 1_1102)

Moving to the ***accommodation*** theme, the concept map revealed the concept of *cost* which is linked to the *care* concept in the ***care*** theme, thus indicating a degree of association between the themes of ***care, accommodation*** and this concept. The co-occurring concepts that are interesting are *risk* and *governmen*t, which seems paradoxical to the *choice* and *consumer* concepts throughout the report. The text blocks from which these concepts and thesaurus-related words were seeded highlight again the government-managed aspects of Australian aged care, particularly the allocation ratios managed by the Department of Health and Ageing.

> The Department of Health and Ageing (DoHA) said that while the planning ratios help manage the Commonwealth’s fiscal risk: … they create an artificial scarcity that limits

> the scope for competition, blunts pressure for efficiency and innovation and deprives consumers of choice. … The result is an industry structure which, while it does secure some important policy objectives (such as geographic equity of access), does not make the most efficient use of scarce resources. (/PC report 2.pdf/PC report 2~4.html 1_712*)*

Continuing with the concept and co-occurrence concepts of *costs supply supported* are the further co-occurring concepts of *insurance, risk, predictable and catastrophic*, there were concerns raised from consultation about how "choice" and "consumer" principles would operate. The *Caring for Older Australians 2011,* terms of reference indicated the need to enable financial sustainability of aged care into the future for the Australian Government. Yet, the text blocks associated with these concepts revealed a number of tensions and concerns. Submissions to the Commission reported concerns about older people's capacity to incur additional costs and to pay accommodation bonds, aspects that link to the themes of ***providers*** and ***accommodation****,* the next highest ranked themes in the map. The narrative associated with these themes are associated with new recommendations regarding payment for rooms (called refundable deposits) as people entered a residential care service, charges for living expenses to be included, and access to additional services providers may offer. There were also concerns that providers would take advantage of older Australians and charge the money but not deliver the additional services. There were also concerns that the push to a market approach would disadvantage a portion of older Australians without the means to pay:

> Protects consumers from market power of providers and encourages the supply (and choice) of aged care services. (/Productivity Report.pdf/Productivity Report~6.html 1_1199)

> Exploitation of consumers (accommodation payments and additional services) pending the deepening of the market. (/PC report 2.pdf/PC report 2~38.html 1_8291)

In addition to generating the ranked concept list, Leximancer calculated through a co-occurrence matrix how these concepts were related. Using Bayes' law, it also determined prominence scores for each concept. A prominence score in Leximancer is defined as an "absolute measure(s) of correlation between category and attribute and can be used to make comparisons over time" (Leximancer, 2021). These quantitative analyses revealed noteworthy insights related to the *Caring for Older Australians* report (Productivity Commission, 2011).

5.3.4 *Terminology Observations in the Report*

It is noteworthy that the concept of *choice*, which later became a foundational element of policy rhetoric, ranked 42nd in the Leximancer table, accounting for 4% of terms. Leximancer offered supplementary tables to analyse co-occurrence and prominence scores based on Bayes' law of probability. Further analysis revealed that the co-occurrence count, indicating how frequently concepts appeared together in text blocks, showed the term *resident* as a concept appearing alongside *choice* 14 times, while *consumer* and *recipient* each appeared with *choice* 18 times. Additionally, *resident* and *funding* co-occurred 28 times.

The prominence scores (see glossary table earlier, depicted as **Table 18**) associated with the various terms used to refer to people are presented in Table **22** below. In this table, *choice* and *consumer* have the highest prominence score of 5.79, followed by *recipients* at 3.11. According to Bayes' law, scores of 1-3 are considered weak and scores of >3 are classified as substantial. In this instance, the concepts of *consume*r and *choice* appearing together in the text blocks coded by Leximancer were likely to occur; in other words, each time *consumer* was mentioned, so too was *choice* (Professor Andrew Smith, personal communication, 6/11/24).

Table 22 Caring for Older Australians Leximancer Prominence Concept Scores

Concept	Care	Quality	Choice	Risk	Funding	Regulation
Resident	1.90	2.51	0.89	1.45	1.42	2.66
Consumer	1.90	2.54	5.79	4.34	2.59	3.4
Person	2.00	1.46	1.97	1.81	2.28	0.29
Recipients	2.25	3.76	3.11	1.69	3.83	1.22

5.3.5 *Review Conclusion*

This report was regarded as far-reaching in terms of its scale of engagement and approach, and the recommendations reflected older Australians' desire to remain at home with supports for as long as possible, and the report made many recommendations with regards to residential care and how it operated. The commissioners acknowledged that to achieve

the proposed reform recommendations "would require extensive legislative change and changes to business practice and culture"(/PC report 2.pdf/PC report 2~38.html 1_8326). In addition, the language of enhanced "choice" and "control" was central to the recommendations for older Australians with regards to their care. To corroborate these findings and the proposed recommendations, the Minister for Mental Health and Ageing at the time of the report, Mark Butler, validated these findings by conducting a listening tour to further understand the concerns of older Australians before proceeding to a response and then new legislation (Butler, 2015).

The *Caring for Older Australian Report* (Productivity Commission, 2011) culminated in the Aged Care (*Living Longer Living Better) Act 2013* (Cth), becoming known as LLLB reforms. This new Act and the associated reforms became an amendment to the existing *Aged Care Act, 1997,*(Cth). The reform agenda that ensued from this landmark report saw significant structural reform to the wider aged care sector. The following two reports presented below demonstrate the prevailing policy positions resulting from the recommendations and implementation plan.

5.4 Document 2: Aged Care Roadmap 2016

5.4.1 Background and Context to the Report

In April 2015, the Hon. Mitch Fifield, Federal Assistant Minister for Social Services, tasked the Aged Care Sector Committee (the Committee) to develop a roadmap to advise on future directions for aged care in Australia. The Committee membership consisted of a broad representative group of key leaders from peak advocacy bodies, provider and consumer lobby groups and major provider peak bodies representing the for-purpose and not-for profit-providers[4], union leaders, representatives of DoHA and the regulatory agencies (see Chapter 3 for a full list). The Minister for Health appointed David Tune PSM, as the committee chair, who was an experienced member of the public service, with DoHA staff providing secretariat support (Woods & Gilchrist, 2020).

[4] There were a number of Australian aged-care lobby groups, representing providers. These lobby groups followed the designation of providers not-for-profit represented by ASCA, for-profit or private LASA and listed providers by The Guild. These groups were amalgamated in 2022.

The Committee built on recommendations from *The Caring for Older Australians Report* (2011) (Productivity Commission, 2011). The nine domains considered by the Aged Sector Committee were posed as the following questions (the responses to which constituted their *Road Map* report (Tune, 2016)):

1. How do consumers prepare for and engage with their aged care?
2. How are eligibility and care needs assessed?
3. How are consumers with different needs supported
4. How do we make dementia core business throughout the system?
5. What care is available?
6. Who provides care?
7. Who pays?
8. How will the formal and informal workforce be supported?
9. How will quality be achieved?

The report appears different in presentation style from the other reports considered in this review. The Committee determined what was currently in place for each domain, a rationale for change and what needed to be achieved and, finally, a "destination" or desired future state or outcome to be realised over the time horizons set. The time horizons ranged from short term (within two years), medium term (three-to-five years) and long term (five-to-seven years). **Table 23** below depicts each of these domains and the "destination" considered by the Committee to achieve the final goal, "a consumer driven, market based, sustainable aged care system**"** (Tune, 2016, p. 2).

The Aged Care Roadmap report was delivered to the Senator Mitch Fifield in April 2016, with the intention of generating discussion across the aged care sector and government regarding future reforms to aged care. This Committee enjoyed considerable bipartisan support and was also perceived to hold influence with the Liberal government of the day (Woods & Gilchrist, 2020).

Table 23 *Aged Care Roadmap* Destination Summary for the Australian Aged Care Sector (Tune, 2016)

Domain	Destination	Goal
How do consumers prepare for and engage with their aged care?	Consumers, their families and carers are proactive in preparing for their future care needs and are empowered to do so.	**A consumer driver, market based, sustainable aged care system"**
How are eligibility and care needs assessed?	A single government-operated assessment process that is independent and free, and includes assessment of eligibility, care needs and maximum funding levels.	
How are consumers with different needs supported?	Regardless of cultural or linguistic background, sexuality, life circumstance or location, consumers can access the care and support they need.	
How do we make dementia core business throughout the system?	The community is dementia-aware and dementia care is integrated as core business throughout the aged care system.	
What care is available?	A single aged care and support system that is market-based and consumer-driven, with access based on assessed need.	
Who provides care?	A single aged provider registration scheme that recognises organisations registered or accredited in similar systems, and that has a staged approach to registration depending on the scope of practice of the providers.	
Who pays?	Sustainable aged care sector financing arrangements where the market determines price, those that can contribute to their care do, and government acts as the "safety net" and contributes when there is insufficient market response.	
How will the formal and informal workforce be supported?	A well-led, well-trained workforce that is adept at adjusting care to meet the needs of older Australians.	
How will quality be achieved?	Greater consumer choice drives quality and innovation, responsive providers and increased competition, supported by an agile and proportionate regulatory framework.	

5.4.2 Leximancer Analysis and Outputs

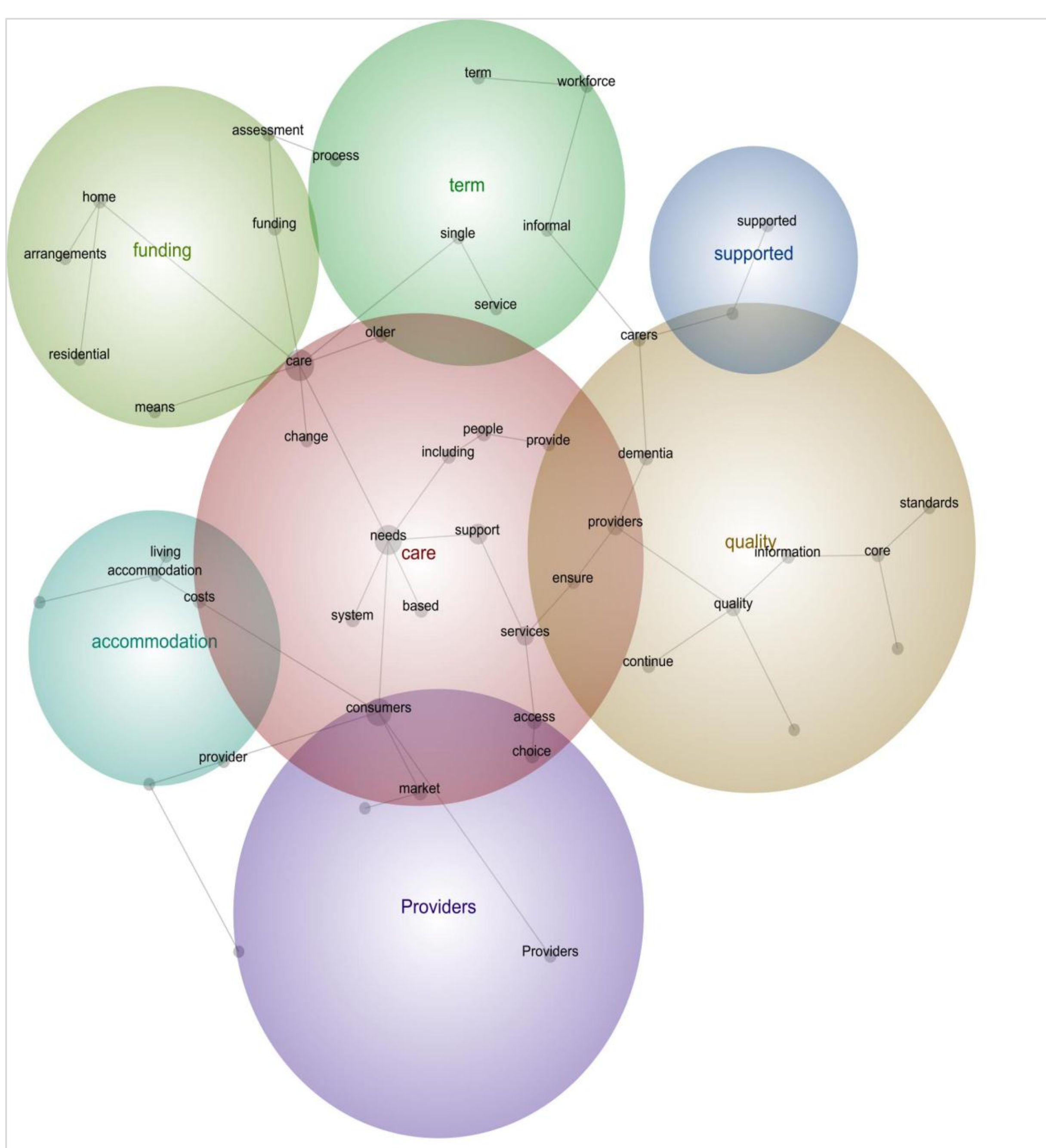


Figure 18 Leximancer Concept Map for the *Aged Care Roadmap* Report (2016)

Table 24 Themes, Concepts, Co-Occurring Concepts and Thesaurus Words Associated with the *Aged Care Roadmap* Report (2016)

Theme	Concept	Count	Relevance	Co-occurring concepts	Thesaurus-identified words
Care 401 hits	Care	277	100	costs, home, residential	care, aged, home, residential
	Needs	229	83	response, ensure, older, costs	government, need, eligibility, insufficient
	Consumers	205	74	costs, choice, living, accommodation	costs, contributions, protections
	Support	99	36	carers, information, informal	resources, emotional, physical
	Services	85	31	market, ensure, access, service	flexibility, provision, timely, improved, dignity
	Providers	51	18	registration, provide, quality, choice	fund, design, agile
	People	43	16	dementia, older, carers, living	people, older, homes
	Choice	45	16	costs, choice, living, market, needs	consumer contributions, protections
	System	49	18	future, market, dementia, older	system, driven, fiscally, reforms
	Market	44	16	response, living, costs, services	market, insufficient, unique
Quality 170 hits	Quality	54	19	standards, information, choice, core	quality, drive, competition, assurance
	Dementia	41	15	people, carers, core, system, quality	evidence, translated, aware, knowledge
	Information	36	13	quality, standards, service, choice	information, published, decision-making, reliable
	Carers	30	11	informal, place, older, support	families, unpaid, practical
	Core	35	13	standards, dementia, single, registration	core, business, discriminate

Theme	Concept	Count	Relevance	Co-occurring concepts	Thesaurus-identified words
Term 127 hits	Term	41	15	service, change, registration, home	term, medium, long, short, narrative
	Process	25	9	assessment, funding, provide, older	process, empowerment, operated, approval
	Single	23	8	standards, registration, assessment, core	single, distinction, operated, recognised
	Workforce	28	10	informal, supported, older, carers	workforce, roles, attracting well-led, well-trained
Funding 107 hits	Funding	32	12	assessment, process, older, arrangements, means	funding, maximum, free, streams, administer
	Home	39	14	residential, assessment, funding,	home, charges, assess, spectrum
	Assessment	27	10	process, funding, means, service	assessment, operated, charges, wellbeing
Accommodation 86 hits	Accommodation	24	9	living, costs, means, arrangements residential	accommodation, living, everyday, lives
	Provider	28	10	registration, provide, continue, based, quality, choice	provider, scheme, spend, status, preferred
	Living	16	6	accommodation, costs, means, residential	living, everyday, primarily, lives,
	Future	22	8	ensure, change, living, system, older, costs	future, challenges, estimating, views, strong
Supported	Supported	34	12	informal, workforce, carers, choice	supported, agile, actively, encouraged drives

Theme	Concept	Count	Relevance	Co-occurring concepts	Thesaurus-identified words
52 hits					
Providers 48 hits	Providers	73	26	registration, quality, choice	providers, incentive, touch, grow, refund
	Response	12	4	market, continue, living, costs, services	response, insufficient, targeting, determines, acts, certain
	Destination	10	4	living, older, dementia, services, accommodation	destination, needs, system

Notes: Count: The total number of text context blocks across the data in which each concept is identified.

Relevance: The percentage of context blocks that are coded with that concept relative to the most frequent concept in the list. In other words, relevance is a percentage representation of the count value of each concept divided by the single highest count value. Consequently, the most frequent concept will always have 100% relevance, regardless of whether it occurs in all context blocks.

Table 25 Ranked Table of Concepts in the *Aged Care Roadmap* Report (2016)

Concept	Kind	Count	Relevance Percentage
care	word	277	100
needs	word	229	83
consumers	word	205	74
support	word	99	36
services	word	85	31
providers	word	73	26
quality	word	54	19
access	word	51	18
system	word	49	18
choice	word	45	16
market	word	44	16
people	word	43	16
dementia	word	41	15
term	word	41	15
home	word	39	14
information	word	36	13
core	word	35	13
supported	word	34	12
including	word	33	12
funding	word	32	12

5.4.3 Narrative Description of the Concept Map

There are seven graphic themes in the concept map from *The Aged Care Roadmap* report, shown graphically in **Figure 18** and listed in the first column of **Table 24** . The themes in rank order are as follows:

1. ***Care*** (red circle) 401 hits
2. ***Quality*** (khaki circle) 170
3. ***Term*** (green circle) 127 hits
4. ***Funding*** (lime green circle) 107 hits

5. ***Accommodation*** (teal circle) 86
6. ***Supported*** (blue circle) 52 hits
7. ***Providers*** (purple circle) 48 hits

All the themes are connected, indicating high association with the other themes, except for the ***supported*** theme, the only one not connected to ***care***. Thus, the theme ***care*** at the centre of the concept map overlaps with the themes of ***providers*, *accommodation, funding, term*** and ***quality***. The theme ***supported*** to the top of the image overlaps only with the theme of ***quality***. The themes appear to represent both the terms of reference and the final *Aged Care Roadmap report* (Tune, 2016). A closer examination of the themes and concepts in these Leximancer-generated outputs helped expose the report's narrative.

In reviewing the ***care*** theme (red circle) and concepts, the largest dots visible and connected to each other are the concepts of *care, needs and consumers*. Within each of these concepts is a number of co-occurring concepts and thesaurus-identified words that are consistent with them. These are the co-occurring concepts of *costs, home, residential* and *choice*. An initial focus on the concepts of *consumers and choice* reveals that the aim of the report is to move to a

> consumer driven, market based, sustainable aged care system" (/aged-care-roadmap_0.pdf/aged-care-roadmap_0~1.html 1_28).

These two concepts reflect this aim and demonstrate that achieving a consumer-based system requires mutual understanding, as the roadmap states:

> Providers and consumers have the same understanding of aged care being individualised with consumer choice" *(/*aged-care-roadmap_0.pdf/aged-care-roadmap_0~1.html 1_174).

However, the coded text blocks also demonstrate that the aim of the report was to create

> a mixed market where providers can deliver services to self-funding consumers as well as government funded consumers". (/aged-care-roadmap_0.pdf/aged-care-roadmap_0~2.html 1_418).

The report revealed that aged care into the future will need:

> Providers [who] will become more sophisticated in terms of how they market the quality of services to consumers" (/aged-care-roadmap_0.pdf/aged-care-roadmap_0~3.html 1_591).

The rationale for these market-based principles is linked to the concept of *future* on the outer point of the circle. These acknowledge the earlier terms of reference in The *Caring for Older Australians report* (Productivity Commission, 2011) and policy concerns that for aged care to remain sustainable and meet future demand associated with numbers and living longer, contributions were necessary.

> The increasing population of older people who are living longer necessitates an aged care system that is sustainable into the future. The system will need to continue to rely on consumers" contributions, as an increasing source of funding. (/aged-care-roadmap_0.pdf/aged-care-roadmap_0~3.html 1_484)

The theme ***Providers*** is connected with the central ***care*** theme, shown as the large concept dot in the purple circle. The concept *Providers* has a strong line of connection to the concept *consumer* in the ***care*** theme. The co-occurring concepts for the concept *providers are registration, quality* and *choice*. Examining the coded segments demonstrates the centrality of responsiveness to new expectations regarding service delivery

> Providers have greater flexibility and incentive to develop innovative and responsive services that responds to consumer needs and expectations" /aged-care-roadmap_0.pdf/aged-care-roadmap_0~3.html 1_565.

Additionally, with regards to the theme ***quality*** and concepts of *quality* and *standards* is the notion of the increased role older Australians would play in the concepts of *choice and quality*:

> Consumer views and choices will play a critical role in driving quality and innovation in the future. As consumers exercise choice, increased market competition will provide incentives to providers to respond to consumer needs and expectations, and drive competition in quality (/aged-care-roadmap_0.pdf/aged-care-roadmap_0~3.html 1_581.)

Also within these overlapping themes of ***care*** and ***Providers*** are the concepts of *market* linking to *consumers*. The following quote illustrates how those involved in developing the roadmap perceived the various roles associated with this new Australian aged care

market, namely that (1) the Government would provide a safety net for those older Australians who were unable to meet the costs of with service provision and (2) providers could determine a price they expect to receive for services and consumers would be responsible for costs such as accommodation and everyday living expenses.

> Sustainable aged care sector financing arrangements where the market determines price, those that can contribute to their care do, and government acts as the "safety net" and contributes when there is insufficient market response. Consumers will be primarily responsible for their accommodation and everyday living costs, as they have been throughout their lives. Providers will determine how much they expect consumers to pay for their accommodation/everyday living, and care/support costs. (/aged-care-roadmap_0.pdf/aged-care-roadmap_0~1.html 1_71)

Within the ***care*** and ***provider*** themes and their related concepts is the co-occurring concept of *costs*, which appears multiple times in relation to the concepts of *providers*, *care*, *needs consumers choice, market.* The concept of *costs* overlaps with the theme *accommodation* and is linked to the concepts of *consumers*, *accommodation* and *living*. These associations highlight an aspect of the *costs* concept, that while older Australians pay for certain service delivery aspects to support their accommodation choices, the fees also help providers maintain their buildings, as per this statement:

> Providers will set and publish their price for accommodation and everyday living costs. These prices will take account of the costs of maintaining, renewing and expanding their capital stock. (/aged-care-roadmap_0.pdf/aged-care-roadmap_0~2.html 1_446)

To the right of the ***care*** theme in the graphic is the theme ***quality***, which contains the following concepts: *quality, dementia, information, carers, continue* and *core*. These concepts pertain to publishing information and their co-occurrences provide a sense of what the concepts in the report were considering regarding *quality*, *standards*, *performance,* and *quality indicators*. This information was to be published on the My Aged Care portal, as the thesaurus words identify, to provide "assurance" and to "drive" "competition" and "quality", as demonstrated in the following:

> Consumer choice supported by better information to drive competition and quality (/aged-care-roadmap_0.pdf/aged-care-roadmap_0~1.html 1_152) and,

> Publish differentiated performance information on core standards and quality indicators on My Aged Care in order to continue to drive competition and quality (/aged-care-roadmap_0.pdf/aged-care-roadmap_0~1.html 1_155).

The *Accommodation* at the bottom left of the image overlaps the ***care*** theme in the centre. *Accommodation* contains the concepts: *accommodation, provider, living, future* and *care*. The quote associated with this theme reflect the market approaches that were considered to drive sustainable aged care service delivery, as follows:

> Consumers are primarily responsible for their accommodation and everyday living costs, as they have been throughout their lives" (/aged-care-roadmap_0.pdf/aged-care-roadmap_0~3.html 1_473).

Interestingly, the report appears to refer to a shift that older Australians would be able to negotiate prices and costs associated with their preferred choice of provider and that the Government would allow market principles to apply to price as with other commodities associated with daily life.

> Consumers will be able to compare and negotiate the price that they pay for accommodation and living costs with their preferred provider. Government will not regulate provider prices or what consumers choose to pay for accommodation and everyday living. (/aged-care-roadmap_0.pdf/aged-care-roadmap_0~2.html 1_450).

The ***funding*** theme to the left of the image slightly touches the themes of ***care*** at the centre and ***term***. The concepts in this theme are *funding, home, assessment, residential, arrangements* and *means*. The two obvious aspects to this theme are assessment of physical and medical needs, in addition to the various types of support from carers to delay entry to a higher level of care. The supports assessed as necessary are intended to be means tested to reduce the cost to the government or taxpayer; however, the assessment process itself, unlike other aspects of the market-based system, will remain with government.

> A single government-operated assessment process that is independent and free, and includes assessment of eligibility, care needs, means and maximum funding level. Any older person may seek an aged care assessment, including those with the means to self-fund their care and support, to help them to make informed choices about their care. The assessment will consider time limited and ongoing needs, taking into account physical

> and medical needs, emotional wellbeing, existing formal/informal support arrangements and individual circumstances. (/aged-care-roadmap_0.pdf/aged-care-roadmap_0~1.html 1_102).

At the top left of the image is the theme *term*. This theme reflects the report horizons for recommendations and action associated with concepts and action areas such as *workforce* and *service*. The term "horizons" was determined from The *Caring for Older Australians* report, with the "short term" being two (2) years and "long term" five to seven (5-7) years.

5.4.4 Terminology Observations in the Report

The concept prominence score tables accessible through the Leximancer portal demonstrate the frequency with which specific concepts appear together in the text. This research revealed that the terms "resident" and "recipient" did not exist in the roadmap; rather, "consumers" was the dominant term in this key government co-designed report.

The term "consumer" was most closely connected to the concepts *care* and *quality* (both had prominence scores of 142). This was followed by *choice* and *provider* (prominence scores of 42), *consumer* and *market* had a prominence score of 31 and the least prominent term with *consumer* was *funding* (prominence score 13).

Drilling further into the *consumers* concept through the interactive features in the concept map produced an additional concept map, **Figure 19**, which demonstrates the widespread interconnectedness of the *consumers* concept to virtually every other concept across all the themes.

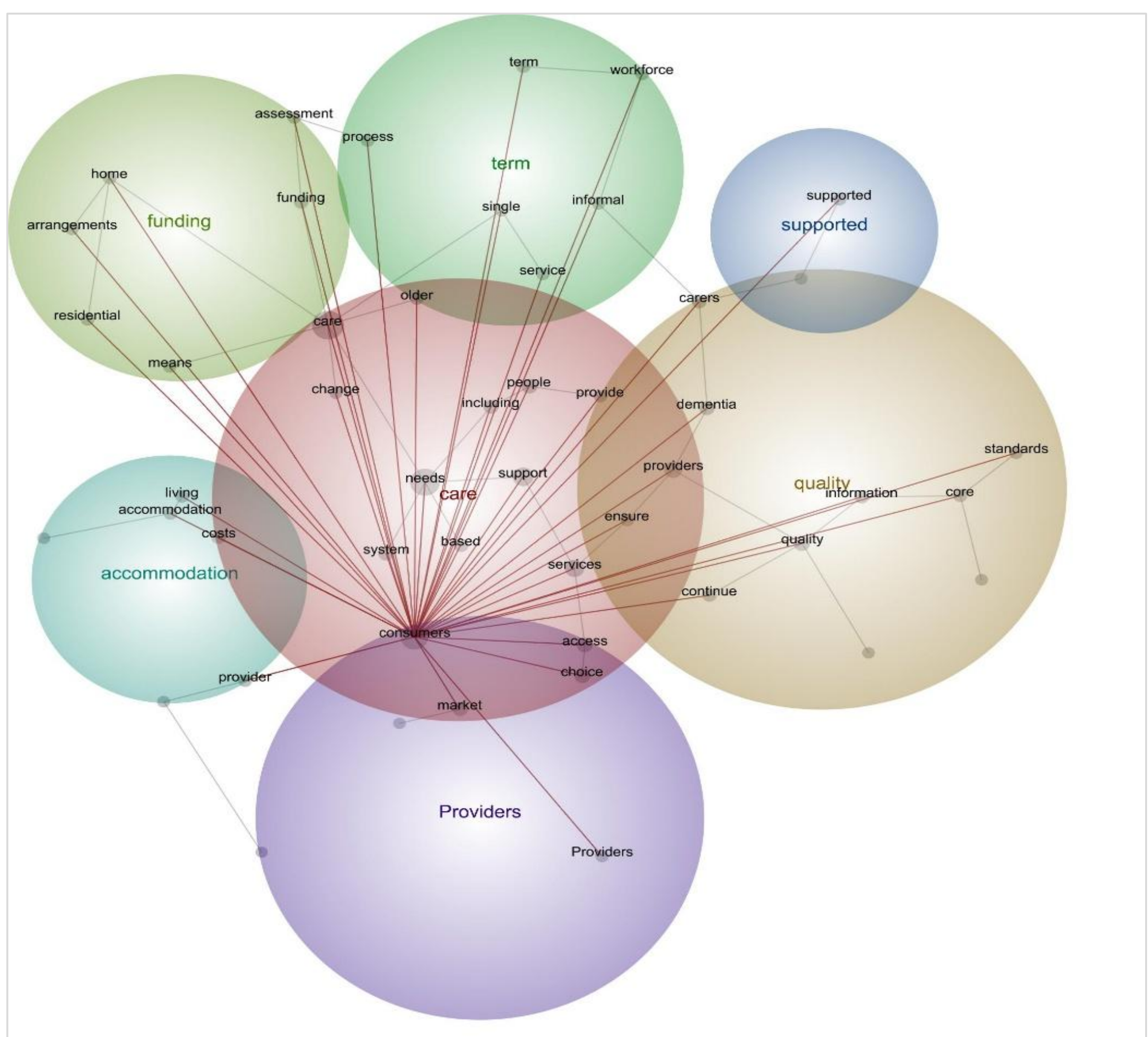


Figure 19 The Concept "Consumer" Connected to All Other Concepts in the *Aged Care Roadmap* Report (2016)

5.4.5 Review Conclusion

Reviewing the *Aged Care Roadmap* report with Leximancer highlighted the push from the Committee members to progress towards greater consumer-oriented approaches in the delivery of aged care services. As a result, the primacy of the consumer in terms of choice and determining quality through available information to support their decisions and choices is very apparent. Also very evident in the report is that "consumer" and "choice" would come with increased costs for living and accommodation.

The next report review is the last in this trilogy of reports that both shaped the legislative policy landscape and changed the sector based on the landmark *Caring for Older*

Australians report, 2011, and the ensuing changes and amendments to the *Aged Care Act, 1997*.

5.5 Document 3: Legislated Review of Aged Care, 2017

5.5.1 Background and Context to the Report

The Honourable Ken Wyatt, Minister for Senior Australians and Aged Care, Minister for Indigenous Health, commissioned this review in accordance with a condition in the *Aged Care (LLLB) Act* 2013 (Cth). The *Aged Care (LLLB) Act 2013* (Cth) stipulated in section 4 that a legislative review must take place within three years of the law coming into effect and stipulated a review of a range of matters including:

- whether unmet demand for residential and home care places had been reduced
- whether the number and mix of places for residential care and home care should continue to be controlled
- whether further steps could be taken to change key aged care services from a supply-driven model to a consumer demand-driven model
- the effectiveness of means testing arrangements for aged care services, including an assessment of the alignment of charges across residential care and home care services
- the effectiveness of arrangements for regulating prices for aged care accommodation
- the effectiveness of arrangements for protecting equity of access to aged care services for different population groups
- the effectiveness of workforce strategies in aged care services, including strategies for the education, recruitment, retention and funding of aged care workers
- the effectiveness of arrangements for protecting refundable deposits and accommodation bonds
- the effectiveness of arrangements for facilitating access to aged care services.

Aged Care (LLLB) Act 2013 (Cth) s 4

David Tune, PSM, who was chosen to conduct the review, was the chair of the Aged Care Sector Reform Committee and in this capacity was responsible for the previous report Aged Care Roadmap 2016 (Tune, 2016). Key inputs into the review were the recommendations from The

Caring for Older Australians report (Productivity Commission, 2011) and the Aged Care Sector Committee’s Report with regards to changes and sustainability for the sector.

This 2017 review involved public consultation with providers, aged care staff, consumers, people with special needs, carers and consumer representatives, in addition to the various aged care peak lobby groups, the Aged Care Sector Committee and the Aged Care Alliance. The review also sought and received submissions. The final report contained 38 recommendations (Commonwealth of Australia, 2019).

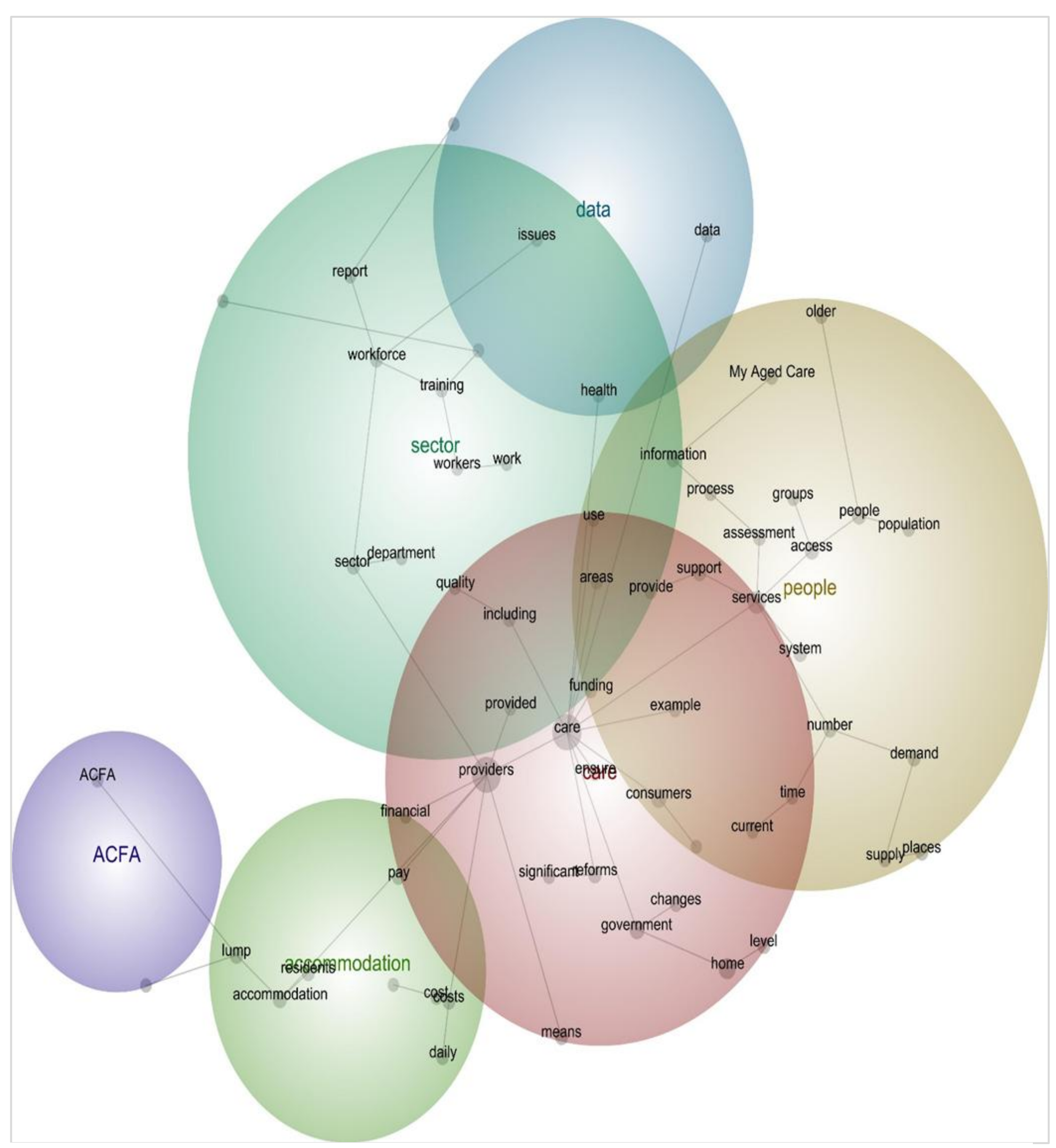


Figure 20 Leximancer Concept Map *Legislative Review of Aged Care* Report (2017)

Table 26 Themes, Concepts, Co-Occurring Concepts and Thesaurus Words Associated with the *Legislative Review of Aged Care* Report (2017)

Theme	Concept	Count	Relevance	Co-occurring concepts	Thesaurus-identified words
Care 2417 hits	care	2058	100	home, places, financial, level, workers, groups	care, aged, residential, home
	providers	1968	96	lump, daily, consumers, accommodation, financial	providers, consumers, needs, consumer,
	services	641	31	consumers, assessment, health, processes	services, outreach, navigator, specialist
	home	581	28	level, means, consumers, daily, places	home, packages, occupancy, queue
	consumers	404	20	process, financial, information, assessment, pay	consumers, balance, representative, formats, confusion
	government	389	19	costs, funding, supply, ensure, places, demand, residents	government, integrate, pays, belonging
	reforms	202	10	changes, significant, funding, access, residents, accommodation	reforms, living longer, living better, subsidy
	means	181	9	pay, daily, cost, resident, accommodation, consumers	means, testing, supplement, subsidy
	level	155	8	demand, consumer’s, home, time, data	level, retiree, gauge, acknowledge, incur
	changes	137	7	reforms, department, system, supply, means	changes, aspect, corporate
	funding	116	6	government, training, sector, workforce	funding, transfer, buildings, allocate

Theme	Concept	Count	Relevance	Co-occurring concepts	Thesaurus-identified words
People 1307 hits	people	322	16	older, population, groups, provide	people, Torres Strait, acquire, severe
	access	286	14	groups, population, information, people	access, quantify, assistive, elder
	system	230	11	changes, support, assessment, supply	system, navigate, consumer, community
	support	220	11	provided, consumers, health, workers, older	support, physical, maintenance, referring
	information	179	9	process, department, use, access, assessment	information, sources, portals, confused
	demand	189	9	supply, current, level, places, data, number	demand, unmet, drive, renew
	places	192	9	supply, number, current, demand, population	places, ratio, allocating, offline
	assessment	165	8	process, consumer’s, services, information, access	assessment, holistic, integrate, outcomes
	number	154	7	places, example, workers, supply, population	number, numerator, declining, gold, licences
	my aged care	152	7	information, process, assessment, system, use, consumers	My Aged Care, layout, enabled
	supply	140	7	demand, places, government, ensure, number	supply, uncapping, constraints, ratios

Theme	Concept	Count	Relevance	Co-occurring concepts	Thesaurus-identified words
Accommodation 621 Hits	accommodation	308	15	lump, residents, daily, pay, costs	accommodation, refundable, bond, deposit, prices
	lump	218	11	accommodation, residents, cost, daily, pay	lump, sum, payments, protections
	residents	197	10	lump, accommodation, daily, pay, cost, means	low-means, estates, protects
	costs	146	7	costs, financial, residents, accommodation	costs, incurred, outweighed, predictable
	daily	133	6	pay, residents, means, accommodation, consumers	daily, basic, name,
	pay	115	6	daily, means, financial, residents, accommodation	pay, image, sustained
Sector 326 Hits	sector	200	10	workers, training, workforce, work	sector, tertiary, not-for-profit, renew
	workforce	201	10	workforce, training, sector	workforce, image
ACFA 143 Hits	ACFA	143	7	lump, accommodation, report, financial, residents	ACFA, report, amendments, balances
Data 110 hits	data	110	5	groups, demand, population, level, department, access, time	data, analyse, gold, overstate,

Notes: Count: The total number of text context blocks across the data within which each concept is identified. **Relevance:** The percentage of context blocks that are coded with that concept relative to the most frequent concept in the list. Simply put, relevance is a percentage representation of the count value of each concept divided by the single highest count value. Consequently, the most frequent concept will always have 100% relevance, regardless of whether it occurs in all context blocks.

Table 27 Ranked Table of Concepts in the *Legislative Review of Aged Care* Report (2017)

Concept	Word	Count	Relevance
care	word	2058	100
providers	word	1968	96
services	word	641	31
home	word	581	28
consumers	word	404	20
government	word	389	19
reforms	word	202	10
means	word	181	9
level	word	155	8
changes	word	137	7
funding	word	116	6
people	word	322	16
accommodation	word	308	15
access	word	286	14
system	word	230	11
support	word	220	11
lump	word	218	11
reforms	word	202	10
workforce	word	201	10
sector	word	200	10

5.5.2 Leximancer Analysis and Outputs

The Leximancer output for the *Legislated Review of Aged Care, 2017* **(Figure 20**) and the ranked table of concepts (**Table 27** above presents in written format the Leximancer map of the concepts that emerged from the *Legislative Review of Aged Care Report* (Tune, 2017). Concepts are represented on the map as dots, and themes, depicted as circles, are a collection of related concepts. The more closely that concepts are co-located on the map, the stronger the association between them.

5.5.3 Narrative Description of the Concept Map

Of the six themes visible in the concept map (**Figure 20**), five are closely connected and indeed overlapping, indicating a high degree of association between them. The one exception is the *ACFA* (Aged Care Financing Authority) theme, which sits alone to the left of the concept map. The themes and associated hits are - *care* 2417 hits, *people* 1307 hits, a*ccommodation* 621 hits, *sector* 326 hits, *ACFA* 172 hits, and *data* 110 hits. These are all listed in the left-hand column of **Table 27** .

The Leximancer output depicts six major themes:

1. ***Care*** (red circle) 2417 hits
2. ***People*** (yellow circle) 1307 hits
3. ***Accommodation*** (lime green circle) 621 hits
4. ***Sector*** (green circle) 326 hits
5. ***ACFA*** (purple circle) 143 hits
6. ***Data*** (blue circle) 110 hits.

Commencing with the ***care*** theme, the concepts of *care, providers, consumers and government* are the largest dots in the map and they travel together on the concept map. The co-occurring concepts associated with these concepts include *consumers*, *financial, means, level, lump, and daily* (among others), thus indicating their interrelationships as they related to aged care service delivery and payment for services. Added to these are the indications associated with the remit of the report, namely, the concepts of *reforms* and *changes* and their co-occurring concepts of *changes significant, funding, access, residents, accommodation, department, system* and *supply*. The coded text blocks revealed some interesting aspects that reflect the remit of the report on the *Aged Care* (*Living Longer Living Better) Act 2013* (Cth) and reform program. This included unsurprisingly the fact that

> the distinction between residential high and low care was removed as part of the LLLB reforms.” (/legislated-review-of-aged-care-2017-report_tune.pdf/legislated-review-of-aged-care-2017-report_tune~5.html 1_960)

Conversely, the report revealed there was an increasing cost for residents as consequence of the reforms, namely

> that care costs were higher for residents who entered care after the reforms (44 per cent) higher than for residents in care immediately before the reforms (34 per cent). (/legislated-review-of-aged-care-2017-report_tune.pdf/legislated-review-of-aged-care-2017-report_tune~8.html 1_1590)

And finally, a surprising association with the intent of the reforms was:

> building activity has generally increased since the LLLB reforms commenced, suggesting that investors are responding positively to the reforms. The 2016 Survey of Aged Care Homes estimates total building activity to the value of $4.7 billion in 2015–16234, compared with $3.8 billion in 2014–15235 and $3.1 billion in 2013–14. (/legislated-review-of-aged-care-2017-report_tune.pdf/legislated-review-of-aged-care-2017-report_tune~10.html 1_2108)

To the right of the ***care*** theme (**Figure 21**)- is the ***people*** theme, which contains the concepts of *people, access, system, demand, support, information*, all of which are linked on the concept map. The co-occurring concepts and thesaurus-related words associated with these concepts are *population, older, demand, supply and access*. Collectively, these concepts and co-occurring concepts reflect several of the terms of reference (see section 5.4.1). They also link across to the ***accommodation*** theme with concepts of *accommodation, lump, residents and costs,* again reflective of the terms of reference and the intent of the LLLB reform that older Australians, having reviewed information, could choose where they wanted to live and receive services. This is indicated by the coded text block:

> For residential care, consumers who have been assessed as eligible can approach any approved residential care provider to request access to services." (/legislated-review-of-aged-care-2017-report_tune.pdf/legislated-review-of-aged-care-2017-report_tune~3.html 1_541)

This approach of personal choice appears to be endorsed by lobby groups, as reflected in the following:

> Consumer representative organisation, Council on the Ageing, endorsed the approach of the Commission to place the consumer of aged care at the centre of the reforms, proposing funding should be attached to the consumer rather than allocated to the aged care service provider. This is fundamental to the current reform process and achieving it across

> the aged care system is essential for the achievement of a consumer focused, market based, high quality and financially sustainable aged care for all across coming decades. (/legislated-review-of-aged-care-2017-report_tune.pdf/legislated-review-of-aged-care-2017-report_tune~3.html 1_624)

The ***ACFA*** (Aged Care Financing Authority) theme that sits removed from the other, tightly-connected themes is a new agency that was established with the LLLB reforms. The remit for ACFA was to provide independent financing information to the government of the day. There are a number of overlapping concepts and co-occurring concepts which link the ***accommodation*** and the ***ACFA*** themes, such as the concepts *lump* and *accommodation*, referring to downpayment methods for accommodation.

The ***sector*** theme, in addition to its finance-related concepts, contains the concepts of *workforce* and *pay*, and the co-occurring concepts of *workers*, *training, workforce* and *work*. Workforce aspects appear to have been captured as a recurring theme from the consultations and workshops conducted as part of the review from coded segments:

> the topic of workforce featured consistently in the workshops with consumers, workers and providers. (/legislated-review-of-aged-care-2017-report_tune.pdf/legislated-review-of-aged-care-2017-report_tune~18.html 1_3839)

The concept of *pay* was seen as a core challenge and relates to another of the co-occurring concepts, of *training* and thesaurus word of *image*.

> Wages in the sector have been, and remain, relatively low and are an ongoing source of concern for both employees and the sector more broadly. Other workforce issues include the need for stronger education and training; the sector expressed concern about the adequacy of entry level qualifications, the role of ongoing education and training in maintaining skills and providing career pathways, and problems with the performance of some training providers. (/legislated-review-of-aged-care-2017-report_tune.pdf/legislated-review-of-aged-care-2017-report_tune~1.html 1_214)

I turn now to observations about terminology in this report as it, that is, the terminology, relates to the research questions.

5.5.4 Terminology Observations Within the Report

In the ranked concept **Table 27** there are two terms to refer to people, *residents* and *consumers*. These are the only terms in the report that refer to people. The concept *residents* as per the table has a count of 197 and a relative percentage of 10% versus the concept *consumers*, which has a count of 404 and a relative percentage of 20%.

Figure 21 below demonstrates the links between the concepts identified by Leximancer. The green lines radiating out from the *residents* concept contained in the theme ***accommodation*** highlight the concept and term *consumer* is strongly linked to the payment of accommodation bonds to move into residential aged care. The overriding concerns associated with this concept are financial and building related, as highlighted previously.

In relation to people, the concepts of *accommodation, lump, daily, pay and cost* are the top ranked concepts. *Lump* as outlined above refers to lump-sum payments associated with deposits for room payments or bonds for the duration of a person's stay in a residential aged care facility. Contained in the submissions to the Review, were the payment options; a daily fee or a lump-sum payment, thus demonstrating the providers' concerns for regarding financial viability and the realities of managing their liquidity.

> The impact of accommodation payment changes on the pool of lump sums, and ability of providers to refund outgoing lump sums, were key industry concerns prior to commencement of the reforms. However, data from the Department of Health (the department) and analysis by ACFA shows that the overall pool of lump sums has steadily increased since 1 July 2014. (/legislated-review-of-aged-care-2017-report_tune.pdf/legislated-review-of-aged-care-2017-report_tune~10.html 1_2092)

Providers were concerned that residents' choice of payment would lead to a preference for daily payments over lump sums, posing a liquidity risk and potentially curtailing investment for new residential care facilities.

> Providers were concerned that residents' choice of payment would lead to a preference for daily payments over lump sums, posing a liquidity risk and potentially curtailing investment. Based on the data reported by ACFA, this has not eventuated, and non-low-means residents continue to favour lump-sum payments. (/legislated-review-of-aged-care-2017-report_tune.pdf/legislated-review-of-aged-care-2017-report_tune~10.html 1_2071)

Yet, the report demonstrates from evidence heard that building was continuing using these deposits:

> Two factors are likely to have contributed to the increase in investment and building activity. They are the increased flexibility to charge lump sums, and the increase in the maximum accommodation supplement (/legislated-review-of-aged-care-2017-report_tune.pdf/legislated-review-of-aged-care-2017-report_tune~10.html 1_2113).

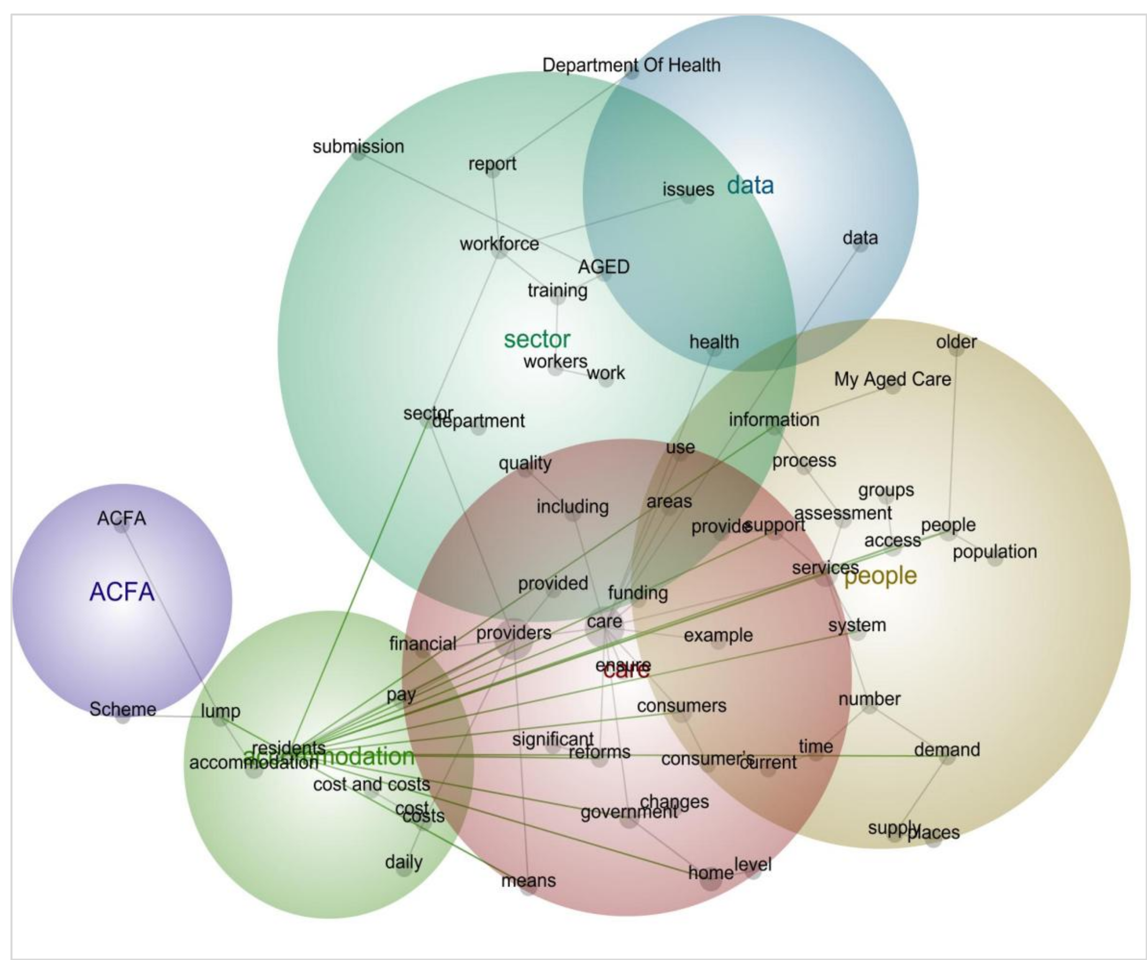


Figure 21 - The Concept "Resident" Linked to All Other Concepts in the *Legislative Review of Aged Care* Report (2017)

The *accommodation* theme further reflects the market dynamics associated with the cost-of-service delivery, particularly the costs of *home* versus costs of *care*.

Conversely, when reviewing the concept *consumer* in **Figure 22**, the concepts that travel with it are *process, financial, information, assessment*, and *pay*. The red lines indicate the concept *consumer* connection to other concepts. Notably, within the Legislative Review report, the term *consumer* was used in the context of sustainability, as illustrated in the quote below:

> The LLLB reforms have been successful in taking Australian aged care further along the road towards a consumer demand-driven and sustainable system that will meet both current and future aged care needs. (/legislated-review-of-aged-care-2017-report_tune.pdf/legislated-review-of-aged-care-2017-report_tune~2.html 1_220)

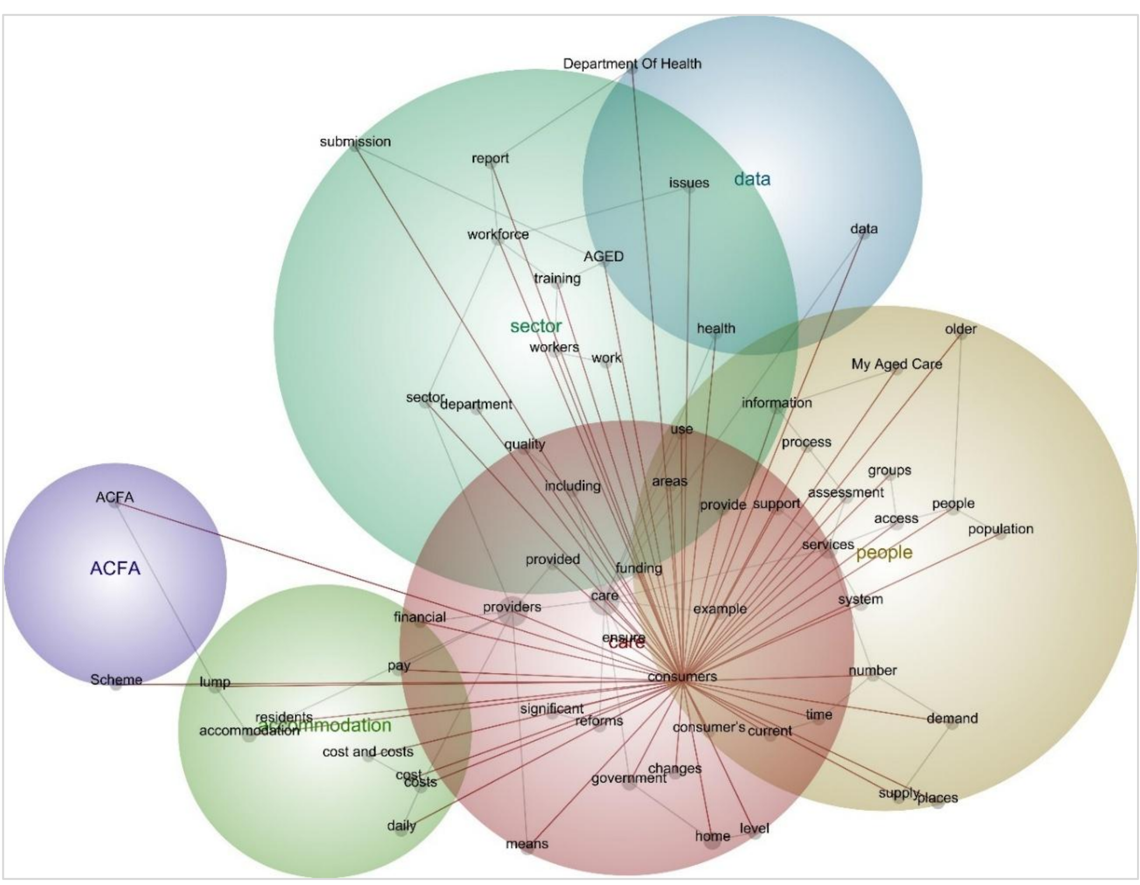


Figure 22 - The Concept “Consumer” Linked to all Other Concepts in the *Legislative Review of Aged Care* Report (2017)

The sustainability aspect is reflected interestingly in the ***care*** theme centrally located at the bottom of the figure. While the theme is labelled ***care***, the dominant concepts again portray the fiscal aspects of aged care service provision, with funding and financial tensions demonstrated in the following:

> These concerned greater consistency in contributions across community and residential care, more comprehensive means testing, lifetime limits on consumer contributions, and the introduction of a government-backed scheme to enable consumers to draw on the equity in their home to pay their aged care costs. (/legislated-review-of-aged-care-2017-report_tune.pdf/legislated-review-of-aged-care-2017-report_tune~7.html 1_1387)

5.5.5 Review Conclusion

These first three reviews showcase the reforms to Australian aged care policy from 2011 with the new *Aged Care (LLLB) Act 2013* (Cth) over the ensuing decade. They highlight the move to a consumer-oriented aged care system with recurring themes of greater choice and control for consumers, improved quality of care and experience and better access to the aged care system and its information through the "My Aged Care" portal. These reforms would also provide sustainable funding models to manage government fiscal risk and enable investment in the building of new residential care facilities for aged care in Australia. However, these policy shifts were to be considered in the last two review reports, which follow.

5.6 Document 4: Review of National Aged Care Quality Regulatory Processes, Carnell Paterson, 2017

5.6.1 Background and Context of the Report

The genesis for this review was the Oakden scandal and perceived systemic failures associated with the Australian aged care regulatory agency, The Aged Care Standards and Accreditation Agency. Oakden was a specialist residential care facility for older people with severe mental illness service. While Oakden was a South Australian state service in Adelaide, two wards, Makk and McLeay, were deemed as “aged care” and consequently regulated by the Federal Aged Care regulator, the Safety and Quality Commission. Barb Spriggs witnessed her husband Bob receiving care that was disrespectful, lacking in empathy and dehumanising (McKellar, 2024). On his behalf and for others, she lobbied and was ultimately one of the whistleblowers which resulted in these last two reports, *Review of National Aged Care Quality Regulatory Processes, 2017 (Carnell & Paterson, 2017)* and *Neglect, 2019 (Royal Commission into Aged Care Quality and Safety, 2019b).* The first of these relates first to quality and regulation and secondly a review of the whole sector.

The South Australian Chief Psychiatrist 2015-2017, Dr. Aaron Groves had reviewed the failures at the Oakden Older Person’s Mental Health Service (Oakden) in SA. *The Review of the Oakden Older Persons Mental Health Service* (Oakden Report) (Groves et al., 2017) had made findings that were highly critical of the leadership, culture and pattern of substandard care, with outdated models of care for people with mental illness, i.e., the overuse of restraints and medication errors. Other care failings included neglect, rough handling and dehumanising practices, which the Aged Care regulator had failed to detect. Following *The Oakden Report* (Groves et al., 2017) and sustained media interest, there remained questions regarding the regulatory processes; why the aged care regulator failed to detect systemic quality of care failure at Oakden and what improvements were required to the wider regulatory system? Oakden as a service was ultimately closed and the remaining residents and patients transferred to a new service.

The Oakden case exposed systemic failures in accreditation and regulation across the entire aged care sector, which led Minister Ken Wyatt to commission this review. He appointed Kate Carnell, a retired politician and businesswoman and Professor Ron

Paterson, a regulation expert from New Zealand, to conduct the review. The review received 400 submissions and conducted more than 40 consultations with families, advocates, peak bodies, providers, health and aged care workers, academics and regulatory experts (Carnell & Paterson, 2017). The final report contained 10 recommendations.

5.6.2 Leximancer Analysis and Outputs

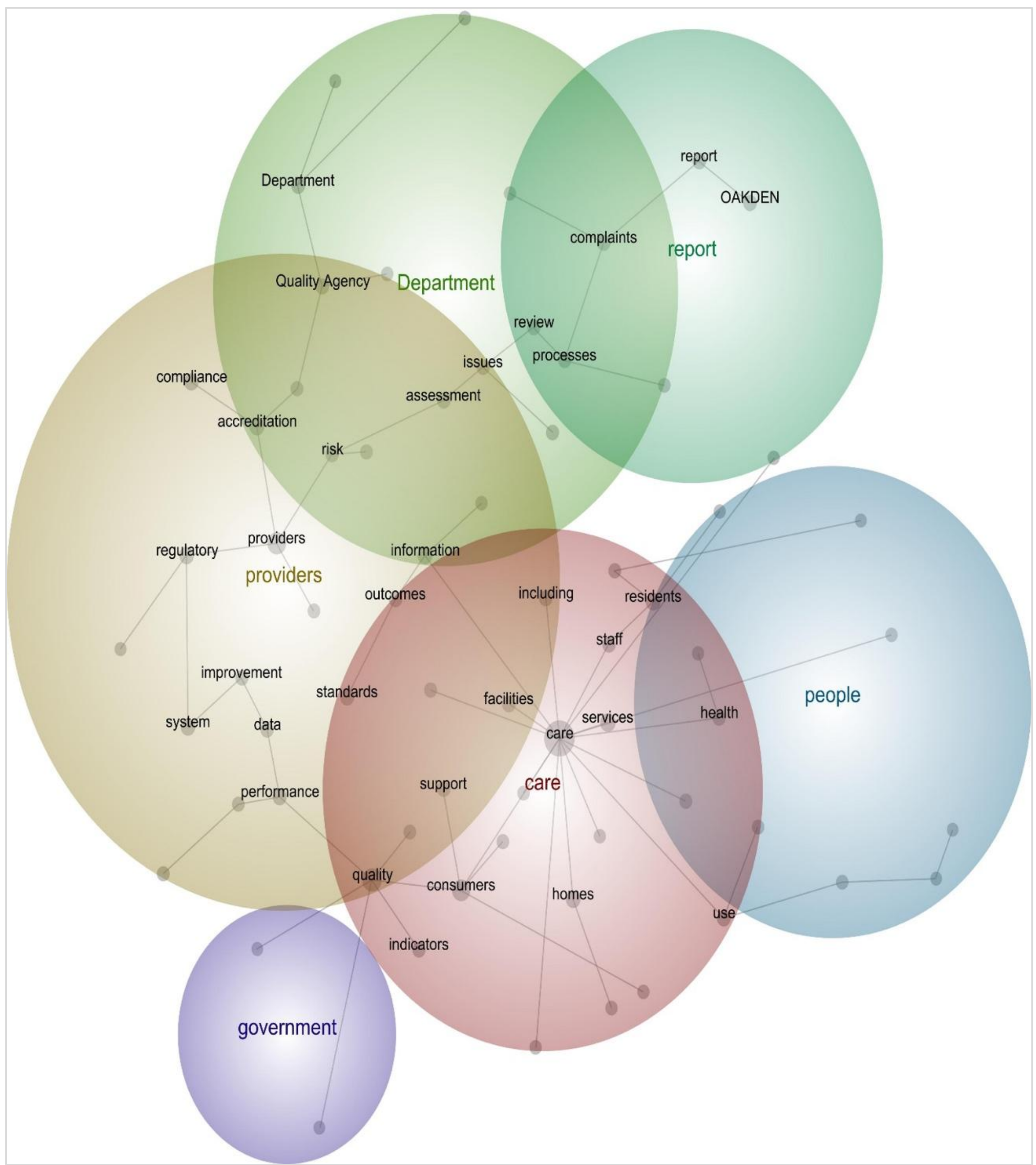


Figure 23 Leximancer Concept Map for the *Review of National Aged Care Quality Regulatory Processes* Report (2017).

Table 28 Themes, Concepts, Co-Occurring Concepts and Thesaurus Words Associated with the *Review of National Aged Care Quality Regulatory Processes* Report (2017)

Theme	concept	Count	Relevance	Co-occurring concepts	Thesaurus-identified words
Care 1447 hits	care	1115	100	health, clinical, ensure, quality, facilities, management	care, aged, residential, recipients
	quality	433	39	indicators, performance, improvement, experience	quality, life, indicator, examine, lives
	consumers	389	35	rights, experience, ensure, support, government	consumer, needs, peak, special
	services	230	21	health, provided, experience, support, government	services, operated, tailored, overwhelmed
	residents	182	16	staff, management, risk, rights, dementia, homes	residents, interview, wellbeing, seriousness, placing
	homes	175	16	nursing, medication, indicators, experience, residents	home, nursing, enrolled, qualifications
Providers 1214 Hits	providers	410	37	performance, process, risk, improvement, response	providers, approved, star-rated
	accreditation	218	20	audit, standards, process, assessment, visits, compliance	accreditation, three-year, revoke, cycle, mandating
	information	191	17	provide, data, rights, include, reporting, performance	sharing, intelligence, capture, database, skill, share
	regulatory	216	19	system, policy, processes, current, government	regulatory, theory, umbrella
	compliance	184	17	risk, accreditation, response, approach, standards, audit	compliance, operations, manual
	performance	143	13	indicators, data, reporting, improvement, system, outcomes	performance, star-rated, analyse, comparison
	standards	152	14	outcomes, accreditation, assessment, process, clinical	standards, clearer, happens, embracing
	outcomes	114	10	audit, standards, performance, management, medication, assessment	outcomes, identifies, cards, inputs, nutrition
Department 583 Hits	Department	171	16	serious, compliance, response, providers, risk, policy	impose, background, notify, secretary
	quality agency	123	11	risk, audit, experience, compliance, visits, review	depending, skills, serious risk, extend, conducts

Theme	concept	Count	Relevance	Co-occurring concepts	Thesaurus-identified words
	issues	118	11	medication, noted, management, serious, facility	issues, oral, conclude, post, hygiene
	review	117	10	audit, processes, practices, serious, assessment, risk	review, CEO, contemporaneous
	processes	119	11	review, regulatory, complaints, outcomes, reporting,	processes, results, copy, assessment, own initiative
Report 462 Hits	report	186	17	response, experience, provided, issues, facility	report, elder, abuse, suspicions
	OAKDEN	179	16	report, provided, facility, issues, audit, regulatory, accreditation	failures, unique, unusual, suffered, sentinel detection
	complaints	158	14	process, medication, issues, information, facility, serious, review	complaints, handling, appeal, anonymous
People 81 Hits	people	81	7	dementia, older, rights, example, health, use, practices	people, detention, liberty, indefinite
Government 54 Hits	government	54	5	policy, health, regulatory, consumers, services, system, providers	childcare, representing, roadmap, difficulty

Notes: **Count -** The total number of text context blocks across the data within which each concept is identified. **Relevance** - The percentage of context blocks which are coded with that concept relative to the most frequent concept in the list. Simply put, relevance is a percentage representation of the count value of each concept divided by the single highest count value. Consequently, the most frequent concept will always have 100% relevance, regardless of whether it occurs in all context blocks.

The rank order of concepts table is presented below. Each of these concepts is represented as dots in the themes in the concept map above.

Table 29 Ranked Table of Concepts in the *Review of National Aged Care Quality Regulatory Processes* Report (2017)

Concept	Kind	Count	Relevance_percentage
care	WORD	1115	100
quality	WORD	433	39
providers	WORD	410	37
consumers	WORD	389	35
services	WORD	230	21
accreditation	WORD	218	20
regulatory	WORD	216	19
system	WORD	196	18
information	WORD	191	17
report	WORD	186	17
compliance	WORD	184	17
residents	WORD	182	16
homes	WORD	175	16
complaints	WORD	158	14
use	WORD	156	14
standards	WORD	152	14
performance	WORD	143	13
facilities	WORD	131	12
assessment	WORD	126	11
support	WORD	126	11

5.6.3 Narrative Description of the Concept Map and Leximancer outputs

The Leximancer output showed that there were six major themes in the review of National Aged Care Quality Regulatory Processes. The themes in rank order were:

1. ***Care*** (red circle) 1447
2. ***Providers*** (khaki circle) 1214

3. ***Department*** (green circle) 583
4. **Repor*t*** (teal circle) 462
5. ***People*** (blue circle) 81
6. **Government** (purple circle) 54

All the themes overlap apart from ***government***, which sits to the bottom left, partially touching the themes of ***care*** and ***providers***. Despite this, all the themes linked in this manner indicate a high degree of association.

Table 28 of the themes' concepts relate to the dots in the concept map. The ***care*** theme has the largest number of hits associated with it. The concept *care* is the largest dot in the ***care*** theme, followed by the concepts of *quality, consumers, services, residents and homes*; all the concepts in the *care* theme are very interconnected and linked.

Moving to the next largest theme with the most hits on the concept map is the theme ***providers***. Here, concepts associated with the subject matter of the report and the concepts reflect the terms of reference and the failure of regulatory processes highlighted by the Oakden scandal. The visible concepts of *providers, accreditation, visits and compliance* travel together into the ***Department*** theme.

The longest concept link is through the themes of ***provider, Department*** and ***report***, which overlap and contain a significantly long concept link through these themes, relating to *policy, regulatory, providers, risk processes assessment, issues, review, processes complaints, report and Oakden*. Further, this link travels to the top of the overlap of the themes *providers* and ***Department*** to reflect the interplay of multiple government agency involvement in regulatory oversight with concepts of *quality agency*, *Department*, and complaints commissioner. Collectively, the interrelated concepts associated with the themes with the most hits, namely, ***care, providers*** and ***Department***, are overlapping and co-occurring concepts that reflect the narrative of the report and the terms of reference: was Oakden an isolated incident or was it reflective of systemic failure? The report appears to rebuke the regulatory agency, stating that the existing system failed the older Australians in Oakden,

> Oakden had significant failures of care, and the Commonwealth's regulatory framework failed to detect them. As a result, many aged care residents, including some of the most vulnerable and unwell in the aged care system, received poor-quality care and suffered as

> a consequence (/review-of-national-aged-care-quality-regulatory-processes-report Carnell.pdf/review-of-national-aged-care-quality-regulatory-processes-report Carnell~6.html 1)

Further, the quotes linked to these three themes and their associated concepts suggest that it was far from an isolated case:

> While the situation at Oakden is far from typical, the circumstances that led to it are certainly not unique. (/review-of-national-aged-care-quality-regulatory-processes-report Carnell.pdf/review-of-national-aged-care-quality-regulatory-processes-report Carnell~1.html 1)

Within the ***Department*** travelling through to the ***providers*** theme are several concepts that appear to reference various agencies related to concepts of *department, complaints commissioner and quality agency*, all of which were responsible for quality and regulation and their interagency management of failure

> While the three regulators have developed memorandums of understanding that describe processes and timeframes for information sharing, the segregation of function generally limits data sharing. (/review-of-national-aged-care-quality-regulatory-processes-report Carnell.pdf/review-of-national-aged-care-quality-regulatory-processes-report Carnell~9.html 1)

Indeed, the concept of *department* and the co-occurring concept of *policy* appear to reflect how unusual it is for the government to have dual roles, both as regulator and policy author, to oversight the sector, as per the following text block:

> However, in an era when consumer choice and competition are frequently invoked as the best means to improve quality, some may question the role of government as a regulator of this sector. (/review-of-national-aged-care-quality-regulatory-processes-report Carnell.pdf/review-of-national-aged-care-quality-regulatory-processes-report Carnell~1.html 1)

Further, related to the concepts of *accreditation, compliance and outcomes* there appears to reference to the regulatory system thus:

> All too often, the Review heard about accreditation by the Quality Agency that was focused on processes rather than outcomes, and appeared to be a 'tick-the-box' exercise.

> (/review-of-national-aged-care-quality-regulatory-processes-report Carnell.pdf/review-of-national-aged-care-quality-regulatory-processes-report Carnell~1.html 1).

Consequently, the reviewers were highly critical of the fragmented regulatory system, with overlapping and multi-agency involvement” and they highlighted that these issues had been known since The *Caring for Older Australians* report (Productivity Commission, 2011) included in this Chapter 5, section 5.2.6 (Report 1). Also, related to both the concepts of *quality agency* and *complaints,* was the Leximancer-generated thesaurus word of *serious* which is also a concept in the ***report*** theme. Use of the tool’s interactive features to understand this further revealed quotes regarding serious incidents and how to define and improve and respond:

> defining a serious incident and improving the response to serious incidents of abuse and neglect, (/review-of-national-aged-care-quality-regulatory-processes-report Carnell.pdf/review-of-national-aged-care-quality-regulatory-processes-report Carnell~17.html).

The coded blocks referenced how to manage serious failure and how to train a regulatory agency in detecting such failures, to protect older Australians. Notably within the ***report*** theme is the concept *time*, which links directly to care and which, on reviewing, refers to *floor time*, which links further to how people with dementia were left on the floor or placed in isolation in Oakden units in distress.

> On direct questioning, the Review was informed of a very disturbing account of what constituted “floor time”. It occurred when during staff interactions with certain consumers the staff would leave the consumer on the floor in considerable distress if they formed the view that intervening to assist the person was not needed immediately, for whatever reason. This is among the most abhorrent approaches to providing care to severely disturbed consumers that any of the Review had encountered in well over 110 years of collective practice. It simply lacks any humanity. This was an example of the type of issue that no accrediting body would ever endorse, if it was aware of its occurrence. (/review-of-national-aged-care-quality-regulatory-processes-report Carnell.pdf/review-of-national-aged-care-quality-regulatory-processes-report Carnell~6.html 1)

Following this overview of the report’s narrative are specifics of terminology observations in this final report.

5.6.4 Terminology Observations Within the Report

In examining how people were referred to in the report, a number of conventions were used. Within the *people* theme, the concepts of *people* and *older* were evident when referring to the clinical needs of the people residing in and receiving care at Oakden.

Though, in the ***care*** theme, *residents* and *consumers* are used. While the concept *consumer* linked to *rights*, *support* and *quality*. The concept map below, **Figure 24**, demonstrates how connected the *consumer* concept is to the other concepts in the map.

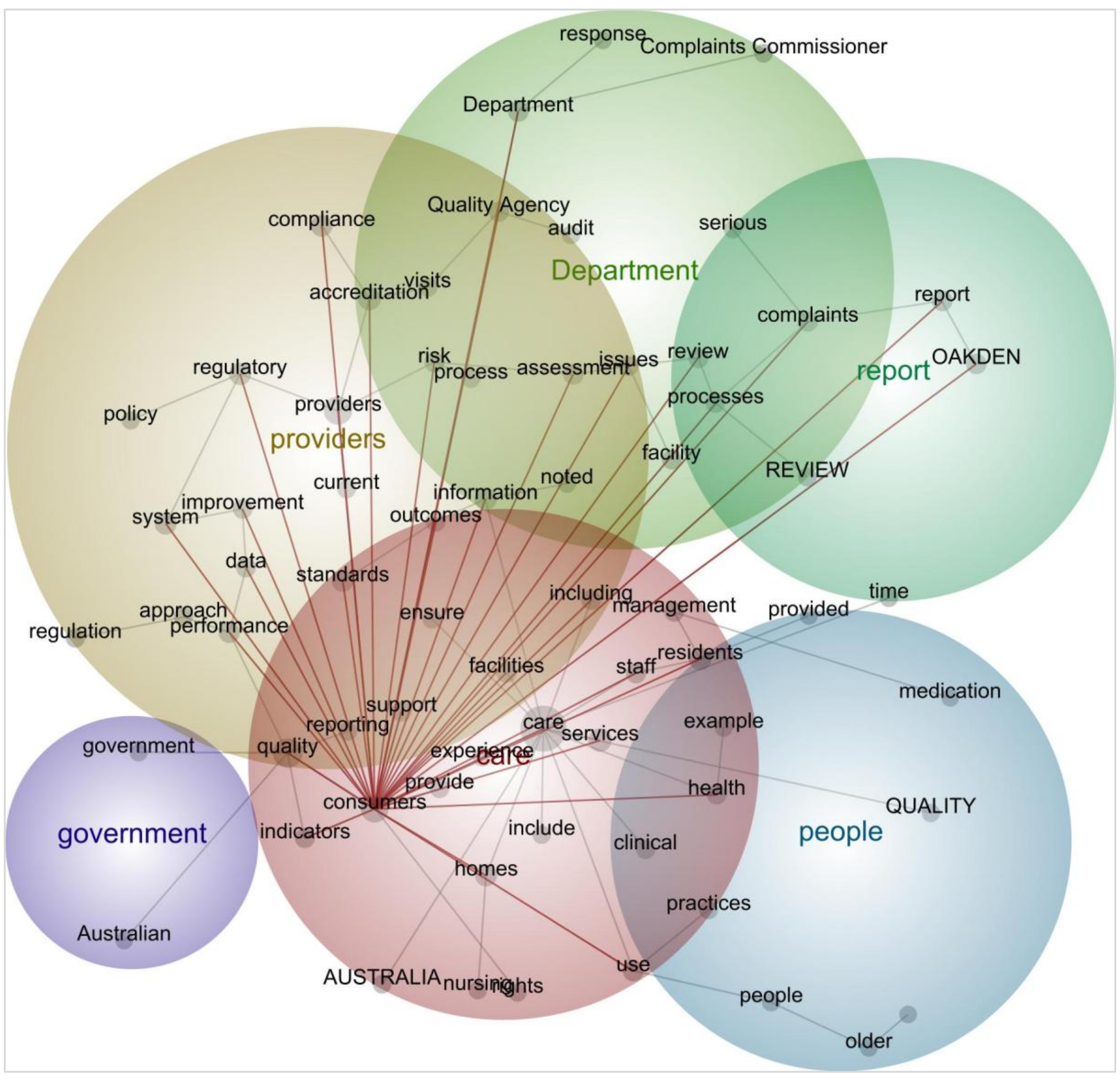


Figure 24 The "Consumer" Concept Connected to Other Concepts in the. *Review of National Aged Care Quality Regulatory Processes* Report, (2017)

Using a similar approach to determine the linkages between *resident* and other concepts across the concept map, **Figure 24** shows that these terms are also linked across the map. The co-occurring concepts with each of these terms provide notable insights. Firstly, they indicate the interchangeability of the terms, although there are differences based on the co-occurring concepts. For example, the *consumer* concept has co-occurring concepts such as *rights*, *experience* and *support*. In contrast, the *resident* concept is associated with *staff*, *management, risks, rights* and *dementia*.

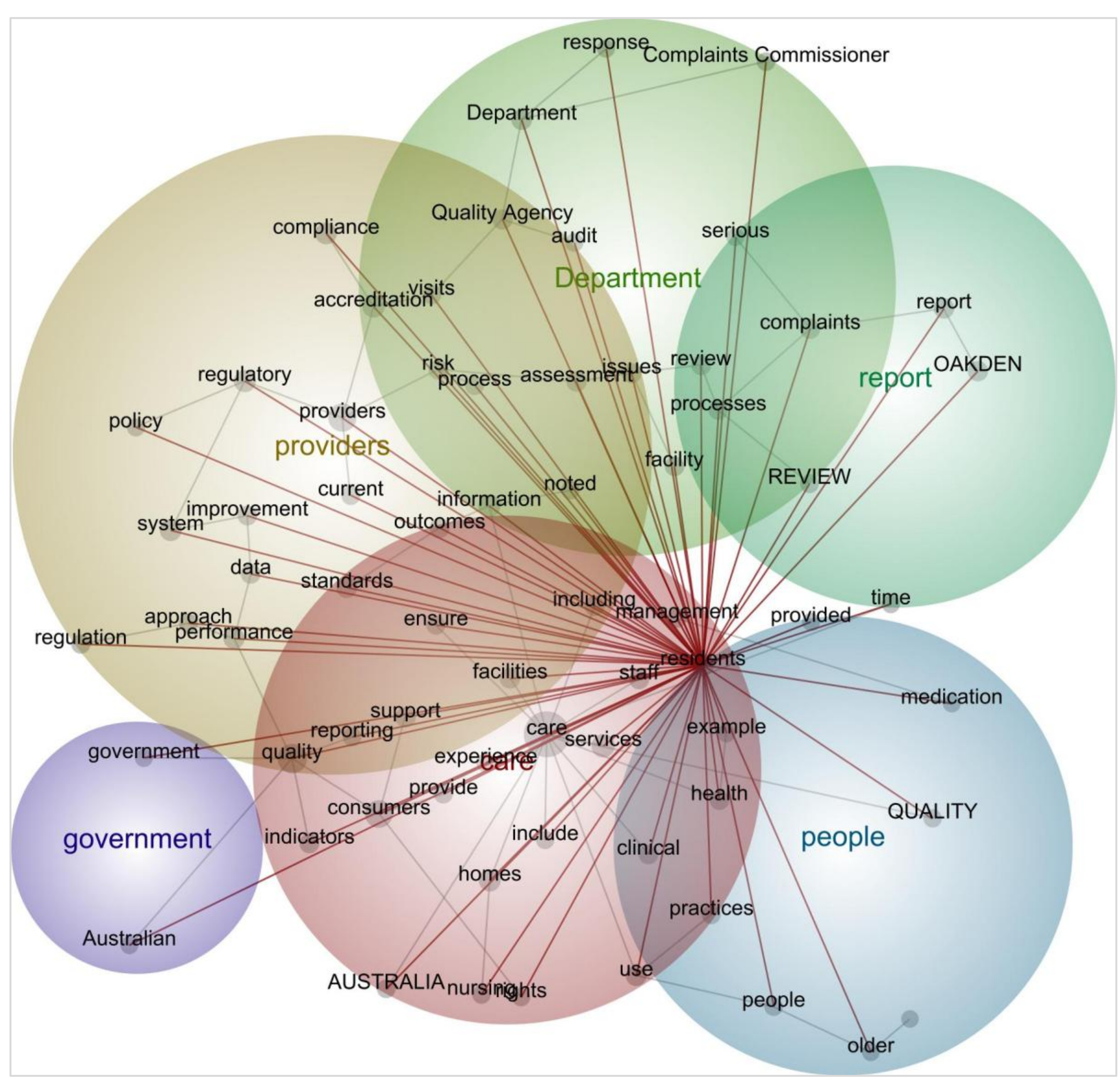


Figure 25 The "Resident" Concept Linked to Other Concepts in the Review of National Aged Care Quality Regulatory Processes Report, (2017)

Secondly, in further examination of the co-occurrence tables, the *consumer* co-occurrence with *care* is 288, and with- *quality* at 134, *risk* 20, *providers* 155 and *regulation* 41. The *resident* concept to each of these is *care* 143, *quality* 37, *risk* 25, *provider* 52 and *regulation* 13. Also, the co-occurrence relates *resident* to *experience* co-occurrence are 38 and *consumer* to *experience* 11 respectively. The ranked concepts reflect the terms of reference and the rationale for the review, specifically, regulatory failure, quality failure, compliance and accreditation. It is interesting to note that the *experience* and *rights* concepts both feature at 6%. In reviewing the concept co-occurrence, *quality* to *outcomes* appear together on 42 occasions and *quality* to *experience* on 31 occasions.

5.6.5 Review Conclusion

The Review of National Aged Care Quality Regulatory Processes report appears very different in its tone and observations from the three earlier reports analysed in this chapter. This report highlighted the failures associated with the clinical aspects of care delivery and support for older people. In addition, it revealed the failure of the regulatory bodies which were charged to protect and support older people from practice settings that were meant to support them. Consequently, older people were undermined not only by deficits at the point of care but also by the systems designed to regulate and uphold standards of care delivery.

The dominant terms used to refer to people in this report were *resident* and *consumer*. While its main findings revealed a fragmented regulatory approach to aged care, the reviewers also identified a fundamental paradox between the governments espoused policy position of consumer choice and market competition as levers to improve quality of care. Indeed, in their recommendations, the report's authors cautioned and countered the dynamic of the previous three reports discussed in this chapter as follows:

> We caution the government not to establish a regulatory system around a consumer-driven market before the market is ready to take on this role. (/review-of-national-aged-care-quality-regulatory-processes-report Carnell.pdf/review-of-national-aged-care-quality-regulatory-processes-report Carnell~13.html)

Instead, the recommendations focus on enhanced regulation and mandatory indicators, while reiterating recommendations from the earlier reviews presented here with regards to complaints processes to protect older Australians.

5.7 Document 5: Neglect, The Royal Commission into Aged Care Quality and Safety, 2019

5.7.1 Background and Context to the Report

This Royal Commission was announced by Prime Minister Scott Morrison following the aforementioned Oakden failure and the sustained media scrutiny which dominated all forms of media for most of 2018, culminating in the ABC *Four Corners* two-part investigative report (Connelly et al., 2018).

The Commission heard evidence over two years from 641 people, received 10,574 submissions and 6,800 phone calls. Over the course of the inquiry, it conducted 23 hearings over 99 days and held community forums. It also commissioned research, conducted workshops and visited international experts and sites. All of this informed the final 148 recommendations. The total cost of the RCACQS was $91.7M, excluding the cost to providers or agencies that participated in the hearings (Royal Commission into Aged Care Quality and Safety, 2021, p. 146).

The Commission’s terms of reference were amended during the Covid-19 pandemic to examine preparedness and infection control, bearing in mind the services faced attendant challenges of protecting people with the heightened infection control measures required. Finally, the interface with the acute health system as people deteriorated and required enhanced modalities of care was examined. Ultimately, the inquiry produced three separate reports, reflecting its changing scope, extended timeline and the extensive volume of evidence gathered. The interim report, *Neglect, 2019* (Royal Commission into Aged Care Quality and Safety, 2019b), and the only report available at this stage, was used for this phase of the study.

5.7.2 Leximancer Analysis and Outputs

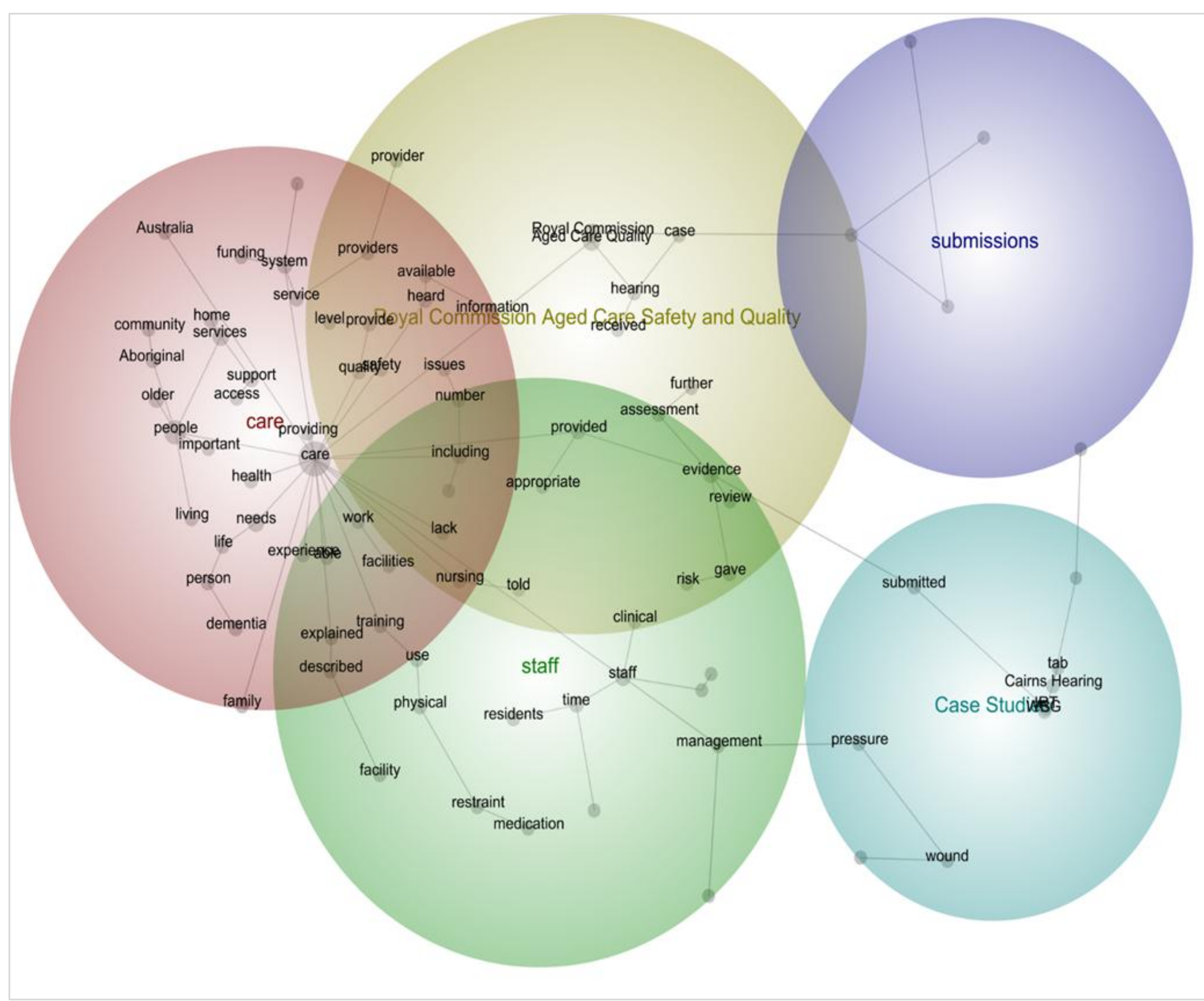


Figure 26 Concept Map of the *Neglect, Report (*2019)

Table 30 Theme, Concepts, Co-occurrence and Thesaurus Words Associated with the *Neglect* Report (2019)

Theme	Concept	Count	Relevance	Co-occurring concepts	Thesaurus-identified words
Care 4027 Hits	Care	3122	100	services, quality, providing, funding, system	younger, sector, programs, recipient,
	People	1284	41	older, living, access, community, services	people, younger, older, homelessness, navigating
	Services	549	18	access, providing, service, home, funding, health	services, intensity, distance, regions, community
	Needs	578	18	older, support, person, level, residents	needs, unmet, meets, moment
	System	371	12	access, safety, older, quality, funding	system, navigate, longstanding, maze, abandonment,
	Home	370	12	nursing, support, funding, services, provider	home, rebalancing, pricing, correlation, assets
	Quality	312	10	safety, life, review, clinical, system, provider	quality, compromise, market-based, expects
	Older	419	13	people, health, system, support, needs, person	older, laden, colonies
	Providers	262	8	service, funding, provider, information, quality, services	providers, approved, thin, prospective, caregivers, dodgy
	Person	270	9	able, older, living, needs, experience, life, family	person, spouse, sedating, advises, endure, impractical
	Life	160	5	quality, clinical, health, food, person, living	life, expectancy, nearing, cure, use-by
	Experience	139	4	described, living, dementia, mother, family, nursing	experience, disabled, policymakers, isolating, debacle, stretched
	Funding	138	4	providers, nursing, home, services, level, system	funding, viable, siloing, allocate
Royal Commission into Aged Care Safety and Quality (ACRC)	Aged Care Quality	803	26	heard, received, submissions, evidence	officials
	Evidence	605	19	gave, heard, submitted, received, hearing	gave, evidence, summarised
	Providers	262	8	service, funding, provider, information, quality, services, case	providers, approved, thin, prospective, caregivers, dodgy
	Hearing	185	6	cases, issues, evidence, heard	hearing, counsel, glasses, proceed, tendered

Theme	Concept	Count	Relevance	Co-occurring concepts	Thesaurus-identified words
2060 Hits	Received	132	4	submissions, evidence, response, mother	received, slipped
Case Studies 1935 Hits	Wound	176	6	management, pressure, hospital, nurse, staff	wound, heel, sacrum, irreversible
	Pressure	133	4	wound, management, risk, hospital	pressure, stockings, sore, healed
	Nurse	138	4	wound, gave, nursing, told, mother, clinical	nurse, discovery, fill, educator, consented, sleepy
	Statement	260	8	review, physical, facilities, medication	statement
Staff 1511 Hits	Staff	503	16	training, nursing, wound, management	staff, rosters, disruptive, up-to-date, assassin
	Time	412	13	pressure, mother, told, restraint, wound, hospital	time, elapsed, consuming, transitional, inadequacy
	Residents	206	7	facilities, clinical, resident, review, staff	residents, protecting, practised, intrusive
	Physical	161	5	restraint, use, medication, policy, dementia	physical, dementia, expired,
	Management	181	6	wound, pressure, clinical, medication	management, post-discharge, deduced, flounder
	Lack	145	5	facilities, management, clinical, appropriate, access, issues, food	lack, clarity, responsive, annoying, bleak, unsavoury
	Risk	158	5	pressure, safety, submitted, resident, physical, restraint, health	risk, imminent, revoke, misadventure
	Clinical	151	5	management, nursing, residents, medication	clinical, practised, duplicate, educator
	Training	128	4	work, dementia, staff, management, health	training, employer, vocational, perfect
	Facilities	123	4	residents, lack, nursing, restraint	facilities, researched, searched, expired
	Restraint	142	5	physical, use, policy, risk, medication, dementia, resident	restraint, chemical, limitation, deconditioning
	Nursing	122	4	home, staff, clinical, nurse	nursing, assistant, hostel, two-tier, bleak, layered
	Medication	139	4	use, management, physical, resident, restraint, clinical	medication, mismanagement, discrepancy

Theme	Concept	Count	Relevance	Co-occurring concepts	Thesaurus-identified words
	Policy	98	3	restraint, physical, use, further, funding, service, older	policy
Submission 163 Hits	Submissions	163	5	response, received, case, issues	submissions, post hearing
	Report	153	5	response, nurse, assessment, review	report
	Department of Health	120	4	provider, restraint, received, physical, report, risk, residents	Department of Health, stakeholders, industry

Notes: Count: The total number of text context blocks across the data each concept within which is identified. **Relevance:** The percentage of context blocks that are coded with that concept relative to the most frequent concept in the list. Simply, relevance is a percentage representation of the count value of each concept divided by the single highest count value. Consequently, the most frequent concept will always have 100% relevance, regardless of whether it occurs in all context blocks.

Table 31 Ranked Table of Concepts in the *Neglect* Report (2019)

Concept	Kind	Count	Relevance percentage
care	WORD	3122	100
people	WORD	1284	41
tab	WORD	655	21
evidence	WORD	605	19
needs	WORD	578	19
services	WORD	549	18
staff	WORD	503	16
older	WORD	419	13
time	WORD	412	13
system	WORD	371	12
home	WORD	370	12
quality	WORD	312	10
dementia	WORD	294	9
provided	WORD	287	9
person	WORD	270	9
support	WORD	268	9
health	WORD	267	9
including	WORD	266	9
providers	WORD	262	8
family	WORD	251	8

5.7.3 Narrative Description of the Concept Map

There are five themes apparent in the Leximancer concept map output, three of which are tightly connected on the left of the concept map, indicating a strong association. These three themes are ***care*, *Royal Commission Aged Care Quality*** and ***staff*.** The two themes to the right of the image, ***case studies*** and ***submissions***, are more isolated and reflective of the legal nature of the Royal Commission and how it conducted the Inquiry, including associated case studies and submissions.

The five themes and their related hits are listed below:

1. ***Care*** (red circle) 4027 hits
2. ***Royal Commission Aged Care Safety and Quality (ACRC)*** (khaki circle) 2160 hits
3. ***Case studies*** (teal circle) 1935 hits
4. ***Staff*** (green circle) 1511 hits
5. ***Submissions*** (purple circle) 163 hits

A closer examination of the themes and concepts in all these outputs, the ranked table of concepts (**Table 31** Ranked Table of Concepts in the *Neglect* Report (2019)) and the Theme, Concept, Co-occurrence and Thesaurus Words Associated with the *Neglect* Report (**Table 30**) used for the following narrative and the concept map helped reveal the report's narrative.

In examining the three closely connected and overlapping circles to the left of image, ***care,*** and ***staff*** themes. Many of the concepts, co-occurring concepts and thesaurus words within these themes, are reflective of care practice and are human oriented, concepts associated with the designation of *younger, older,* and *people* traverse across each of these themes. Within the ***care*** theme, the concepts of *care, people, services* and *needs* are indicated by the largest dots in the theme circle, as reflected in the count scores in **Table 30.**

From evidence received from 30 witness statements and 510 documents about the importance of person-centred care-focused models, the commissioners determined as follows:

> We heard how important it is for staff to know well the person receiving care well. This is facilitated by maintaining consistent staffing so that they can build familiarity and a genuine relationship with the older person. (/interim-report-volume-2_0.pdf/interim-report-volume-2_0~21.html 1_4.)

In addition, the constituent factors influencing person-centred care were listed as:

- the relationships between the person accessing care, people providing support (including family and other members of the community) and the service provider
- broader societal attitudes towards older people
- the perspective and experience of people who access aged care, including the ways in which aged care services are, or are not, person-centred
- good practice care models for providing person-centred aged care

(/interim-report-volume-2_0.pdf/interim-report-volume-2_0~21.html 1_4)

Within the ***care*** theme, the concept of *quality* had co-occurring concepts of *safety, life, clinical, providers*. Interestingly, the thesaurus-identified words associated with this concept were *compromise*, *market-based* and *expects*. The text blocks with these concepts revealed that the commissioners were linking back to the earlier reviews, such *as Caring for Older Australian's Report* (Productivity Commission, 2011) and the *Australian Legislative Review* (Tune, 2017) (see section 5.2.6 and section 5.4.1 in this chapter). The comment associated with these concepts indicates that quality failures were not new to the Royal Commissioners:

> In 2011, the Productivity Commission identified the variability in the quality of care as a key weakness of the aged care system. While the Productivity Commission favoured deregulation and market-based measures in many areas, it recommended that quality and safety standards and oversight remain in Government control, and that these activities be expanded. (/interim-report-volume-1.pdf/interim-report-volume-1~7.html 1_1295)

Conversely, though coded with the concept of *market-based* relates to an interesting paradox with a desire by government to move aged care to a market-based system with less regulation,

> the Australian Department of Health, intended to create a more consumer-driven, market-based and less regulated aged care system" (/interim-report-volume-1.pdf/interim-report-volume-1~7.html 1_1272)

Added to the physical aspects of care provision in the *care* theme that are linked to other themes, there is a clear thread linking *care* to *system, service* and *funding*, with concurrence concepts related to these same concepts. In the *system* concept row of **Table 30** the thesaurus highlights an interesting word, *abandonment*, about which the report says:

> Given that there is so much evidence about these feelings of loss and abandonment experienced in the aged care system, we are dismayed at the apparent lack of acknowledgement and understanding by those who manage and control the aged care system. As a nation, as a community, we must find a way to ease these transitions and ensure that residential care services are made much more attractive and enjoyable for those in care. (/interim-report-volume-1.pdf/interim-report-volume-1~1.html 1_147)

The concepts of *care,* to *experience, quality and life* and co-occurring concepts feature in the ***care*** theme. To inform their evidence base, the commissioners contracted further research on models of care and literature reviews to enhance these elements. Further, the commissioners heard evidence and visited international aged care researchers and sites to inform the quote below regarding the essence of person-centred care within the Australian aged care system.

> The Australian aged care system should be a system which has services that are compassionate, fit for purpose, customised to individual needs and of the highest standards in terms of quality and safety. We must recognise the uniquely individual circumstances for each person receiving aged care. (/interim-report-volume-1.pdf/interim-report-volume-1~2.html 1_330)

However, from the evidence heard and submission received, the lived experience of older people was the opposite to the above. Indeed, the concept *lack*, directly linked to the central point of the *care* theme is noteworthy; as a concept, *lack* accounts for 145 hits and 5% of the text. *Lack* is related to aspects of communication, advanced care planning, and ineffective regulatory oversight pertaining to the quality of care, as in, for example,

> ineffective regulatory oversight of aged care providers, and a lack of focus on the quality of care." (/interim-report-volume-1.pdf/interim-report-volume-1~6.html 1_1175)

Crucially, from the text, *care* was deemed transactional, task-orientated and lacking connection, with older people needing to summon staff for assistance, yet, as reflected in this quote below, the elements of provide person-centred care, while clearly understood, were not evident.

> **Mr XX** an 85-year-old resident at an aged care facility. He emphasised the need for carers to understand what residents want as individuals. He found that, by contrast, his care revolves around the completion of tasks. **Mr XX** described actual care as "connecting with residents in order to see to their needs" and interacting "with them as people". **Mr XX** recognised the effect of this arrangement on both those receiving care and those delivering it: And once the resident immediately is satisfied, it's off to the next most urgent task or call, leaving the parties neither satisfied nor fulfilled (/interim-report-volume-2_0.pdf/interim-report-volume-2_0~21.html 1_4)

This concept of *lack* links to the ***staff*** theme where further concepts relate to *staff, time, resident, management risk clinical*, with a number of the co-occurring concepts relating to *clinical, wounds, medications*, the delivery of care and the *policies and training* associated with these.

Briefly, the Royal Commission into *Aged Care Safety and Quality ("ACRC*") theme reflects the legal aspects of how these failings were considered which are reflected in the concepts of evidence gave, received. Again, the concepts in the *ACRC* theme are reflective of the evidence about aged care practices, with linked concepts of *older people living, dementia, use physical* and *restraint*, which are shown in **Table 30** and confirmed by the following:

> Restraining a person, whether through physical or pharmacological means, is dehumanising and disempowering. It is an affront to dignity and personal autonomy. (/interim-report-volume-1.pdf/interim-report-volume-1~19.html 1_3786)

Given that Oakden scandal had been the antecedent to this Commission, the commissioners considered dementia care and practice they devoted a complete hearing to the topic of care of people with dementia.

Finally, within the ***submissions*** and ***case studies*** themes are concepts that again reflect the legal nature and workings of the Royal Commission. The concept of Cairns appears on the map because the commissioners went to every major Australian city to hear evidence. Other concepts, such as *statements*, *exhibits and tab*, reflect the legal nature of how evidence is heard and commissions conducted.

Within the theme of ***case studies***, are the concepts of *wound, pressure, nurse, statement* in **Table 30** are names of facilities and providers, reflecting the case study approach taken by the Royal Commission to illustrate such central aspects of care as, for example, wound management or a pressure injury. There are also concepts of *nurse, gave* and *evidence*, again reflecting the workings of the Royal Commission. This theme is again reflective of the RCACQS ways of working, according family members the opportunity to provide evidence on behalf of their loved ones in the form of case studies. The issues in the case studies were then used with other evidence to highlight systemic issues associated with quality care.

5.7.4 Terminology observations in the report

Given that in the case study workings of the Royal Commission, people were referred to by their title, “Mrs” has a count of 322, and “mother” 116. The concept *person* is ranked number 17, with a count of 270 in the ranked table of concepts. The prominence scores of the concept *care* to *resident* is 2.48, and *care* to *person* 2.83, which based on Bayes’ law both are considered weak. Conversely, *resident* to *risk* has a prominence score 3.78 which is classed as substantial (Smith, 2024).

5.7.5 Review conclusion

The interim report of the RCACQS discussed in this chapter highlighted the loss of personhood and transactional care which dehumanised people to tasks. It is interesting to note that the antonym to “care” is “neglect”, which ironically was the title of the RCACQS Interim Report; the following quote is particularly relevant to that title:

> We have heard countless stories about how much people grieve for all they have lost when they arrive in residential care. They become “just a resident”, just another body to be washed, fed and mobilised, their value defined by the amount of funding they bring with them. (/interim-report-volume-1.pdf/interim-report-volume-1~1.html 1_136)

5.8 Synthesis of Reports

Table 32 Ranked Table of Concepts from All the Reviews

	Caring for Older Australians	Aged Care Roadmap	Legislated Review of Aged Care	Review of National Aged Care Quality Regulatory Processes	Neglect, Interim Report Royal Commission into Aged Care Safety and Quality
1	care	care	care	care	care
2	services	needs	providers	quality	people
3	needs	consumers	services	providers	tab
4	older	support	home	consumers	evidence
5	residential	services	consumers	services	needs
6	people	providers	government	accreditation	services
7	providers	quality	people	regulatory	staff
8	community	access	accommodation	system	older
9	costs	system	Access	information	time
10	accommodation	choice	system	report	system
11	support	market	support	compliance	home
12	quality	people	lump	residents	quality
13	system	dementia	reforms	homes	dementia
14	health	term	workforce	complaints	provided
15	residents	home	sector	use	person
16	service	information	residents	standards	support
17	including	core	places	performance	health
18	appropriate	supported	demand	facilities	including
19	access	including	means	assessment	providers
20	provide	funding	information	support	family

This comparative analysis of the top 20 concepts from each report from the purposive sample and over the decade of 2011 to 2021, reveals that while *care* emerges as the predominant concept of the reviews, what contributes to the *care* concept (and ultimately the theme) is variable and in some cases indicative of the terms of reference associated with the review/inquiry. Examples include concepts associated with regulation and quality in the Review of National Aged Care Quality Regulatory Processes, or “access” to care in the Aged Care Roadmap and Legislative Review of Aged Care. Following an approach by (Goh & Wilk, 2024), all five reports were further analysed together and the findings are discussed below.

5.8.1 Leximancer of All Five Reports

In light of the above observations and insights, all five reports were analysed together in Leximancer. The output is depicted below.

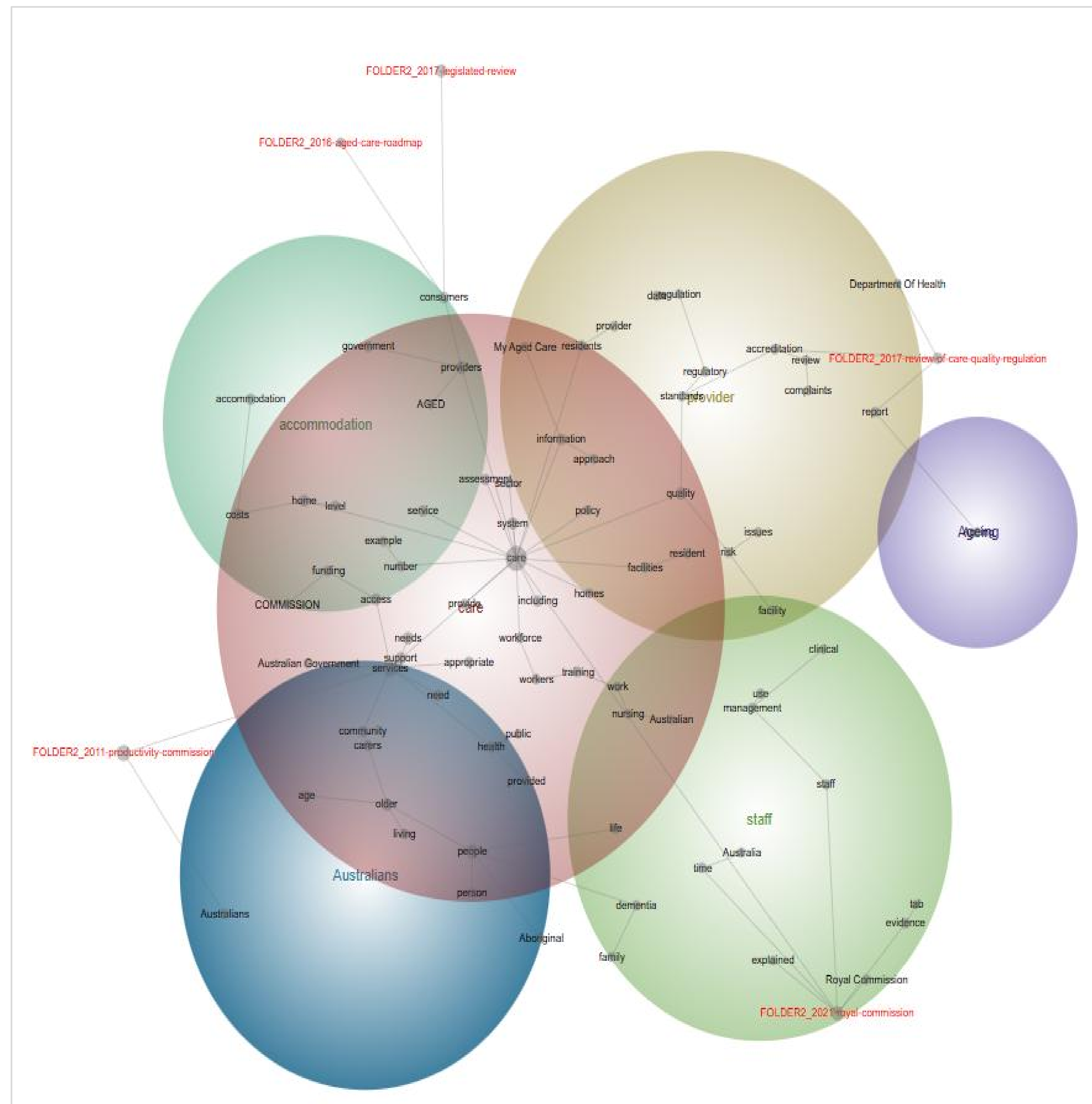


Figure 27 - Leximancer Concept Map of All Five Reports

Six (6) major themes emerged when all the reports were combined. Four (4) of the themes *Australians, staff, accommodation and provider* overlapped closely with the theme *care,* and the theme *Ageing* set to the right linked to the *provider* theme:

1. ***Care*** (red circle) 11443 hits
2. ***Staff*** (green circle) 4634 hits
3. ***Provider*** (khaki circle) 4327 hits
4. ***Accommodation*** (emerald green circle) 3708 hits
5. ***Australians*** (blue circle) 2027 hits
6. ***Ageing*** (purple circle) 136 hits

From this graphic output, a number of observations about the combined reports are immediately apparent, the centrality of the ***care*** theme being foremost, though it overlaps tightly with the ***accommodation*** theme (top left) and the ***provider*** theme (top right). The aspect of the decade is also reflected in this graphic output too, while the *Caring for Older Australians* report is tagged alongside Australians. The other reports circle the concept map in a clockwise manner adjacent to the themes and seem to reflect the terms of reference and focus of the reviews. While the yellow circle at top left is labelled "*provider*", the concepts within it are all reflective of the regulatory processes that underpin the sector.

The ***accommodation*** theme contains the concept *consumer*, which is linked to both the *Legislative Review of Aged Care* and the *Aged Care Roadmap*. The concept *consumer* then links to *providers* and *AGED*. It is also notable that the concepts *government* and *provider* are linked travelling together. The concepts of *accommodation, costs, home* and *care* are also linked, again reflecting the fiscal concerns associated with sector sustainability, the increasing number of older Australians and how in a universal health care model their care could be funded.

Interestingly, in the ***provider*** theme, the concepts are predominantly associated with *regulation, regulatory, quality and standards, accreditation, complaints* with the concept *review* linked together. All these concepts reflect the *Review of National Care Quality Processes* (Carnell & Paterson, 2017) that preceded the Royal Commission (Royal Commission into Aged Care Quality and Safety, 2019b).

5.8.2 Terminology Observations Within All Five Reports

The prominence scores from the collective group of inquiry reports were reviewed to determine two observations: first, the insights derived from the changing nomenclature

and terminology when referring to people and, second, the pre-eminence of the legislative pillars in the care themes.

Table 33 Prominence Table of All Reviews

Values	accreditatio	care	consumer	funding	government	people	person	providers	regulatory	residents	standards
2011 Caring for Older Australian	1.01	1.39	0.67	1.96	0.98	1.17	1.31	1.32	1.27	1.23	1.28
2016 Aged care roadmap	1.00	1.74	5.89	2.60	3.60	1.02	0.20	2.25	0.73	0.47	2.46
2017 Legislatedreview	0.22	1.64	3.75	1.47	4.09	1.15	0.85	1.99	0.38	2.08	0.65
2017 Review of care quality regu	6.07	1.23	2.00	0.47	0.76	0.43	0.43	1.97	5.14	2.28	4.29
2021 Royal commission	0.44	1.21	0.11	0.90	0.31	2.14	2.22	0.72	0.47	0.80	0.51

Both the naming conventions and legislative pillars were colour coded to highlight the highest prominence scores based on Bayes Law. The 2017 *Review of Aged Care Regulatory Quality Processes* has more significant prominence scores than the other reports, all of which pertain to the regulatory process. Indeed, the highest prominence score across the review is the concept *accreditation* at 6.07. The second highest prominence score is the concept *consumer*, interestingly associated with the 2017 report, *Aged Care Roadmap,* at 5.89 and remaining significant in the *Legislative Review of Aged Care* at 3.75. These findings support the initial analysis of word frequency to refer to people earlier in this chapter (**Figures 14 and 15**). Turning to other terminology to refer to people over the five reports, the concept of *people* and *person* would be classified as weak < 3, though increasing with the Royal Commission to 2.14 and 2.22 respectively. *Residents* based on Bayes Law are classified as weak.

Interestingly, ***government*** is significant in the 2016 and 2017 reports at 3.6 and 4.00. So, too, are the scores associated with the concept *providers* through the 2016-2017 reviews.

Additionally, there are a number of observations associated with the reports, which are discussed further in the Phase 1 discussion which follows.

5.9 Phase 1 Discussion

These review reports collectively illustrate the evolution of Australian aged care policy to address the government's twin concerns of financial sustainability and the demand for

services by an ageing population. The reports highlight recurring themes of financing, improving quality and the promotion of person-centred models of care.

In this chapter, the Leximancer outputs for each of the reports have demonstrated that the ***care*** themes (red circles), and the related concepts are notable. Acknowledging that all the concepts contribute to the ***care*** theme, there appears to be an emphasis on the legislative pillars such as financing, budgetary pressures and regulation. There are a number of initial observations regarding how people are referred to and how they may relate to the implementation of person-centred care models that require further exploration from an explanatory sequential mixed-methods perspective.

5.9.1 Terminology to Refer to People

Both stages of this phase of the study have demonstrated a multiplicity of terms with which to refer to people and in many cases the terminology appears to be interchangeable. However, there are a number of conventions and changes in how people are referred too within the reports over the decade. The *Caring for Older Australians report*, 2011, has several terms to refer to people, specifically, *resident, consumer, recipient* and *person*, with co-occurrence scores that identify the term resident with *care*, followed by *recipient* to *care* as the most significant relationships in the analysis.

In the two reports which followed, the *Aged Care Sector Road Map* and *The Legislative Review*, 2017, *recipient* and *person* are no longer evident and indeed in the former report, the term *resident* is absent too with *consumer* used instead. In The *Legislative Review of Aged Care,* the co-occurrence of the concept *consumer* to the concept of *care* increased to 366 versus 155 for the concept of *resident* to *care*.

Although the term *resident* reappears in the *Review of National Aged Care Quality Regulatory Processes* with the term "consumer", over the decade 2011-2021, the term *consumer* became more normative and accepted in the policy documents. Interestingly, however, this shifted again with the Royal Commission, where *resident* and *person* became the more common terms.

These shifting terms become even more interesting when considered with such aspects associated with person-centred care concepts as *quality* and *choice*. *Quality* is a concept in all five reports, but *choice* is reflected in only three, "*Caring for Older Australians"*,

the *Aged Care Road map,* and the *Legislative Review of Aged Care, 2017,* though in this last report, "choice" is associated with both choosing a residential care service and the options associated with accommodation deposit payments and family financing. This is interesting, given the *Living Longer Living Better* 2013 (Cth) amendments and the rhetoric to underpin the changes from government.

5.9.2 Terminology Associated with Legislative Pillars Of Government

Using the interactive features of Leximancer to understand the concepts of *support*, *needs* and *funding* within the *care* themes in each report produced a financial perspective on both care requirements and extra services. It was interesting to see the focus on the funding for room deposits and buildings, the purpose of these fiscal aspects being to support aged care providers as they replenish capital stock from resident room deposits. Another notable observation involves concepts referring to the legislative pillars that underpin Australian aged care, which include the financing and sustainability of the sector and the regulatory processes, particularly in the *Review of Regulatory Processes*, 2017.

5.10 Chapter Conclusion

In Phase 1, the policy and review aspect of the study has established shifting nomenclature to refer to people in the documents. The lexical analysis of these reviews has demonstrated a significant emphasis on the structures of care, and the political imperatives of managing the fiscal tensions associated with the cost and expenditure of aged care, with regards to financing other aspects of social services. The terminology and language changes in these reports, along with other findings related to the financing and regulatory landscape that support the sector, influenced the design and approach to the qualitative phase of the explanatory sequential mixed-methods study. Phase 2 aimed to understand the perspectives of aged care leaders regarding how and if these terminology and policy changes affected the implementation of person-centred care models. The findings are described in the next chapter.

6. PHASE 2 – INTERVIEW AND SITE VISIT FINDINGS

6.1 Introduction

We compose our lives in time, improvising and responding to context, yet weaving threads of continuity and connecting the whole as we move back and forth in memory. (Bateson, 2010, p. 181)

This chapter presents the findings from the interviews with Australian and international aged care executives, aged care researchers and board directors, comprising Phase 2 of the research. The interviews explored participants' perspectives on shifts in terminology from *resident* to *person-centred* to *consumer-centred care* (identified in Phase 1) and the potential impact of these shifts in terminology on implementing person-centred care models. Additionally, interviewees provided insights into the prominence of legislative policy pillars in Australian aged care (revealed by Phase 1's Leximancer analysis) and their relationship to person-centred care implementation. This chapter also draws on site visits for context.

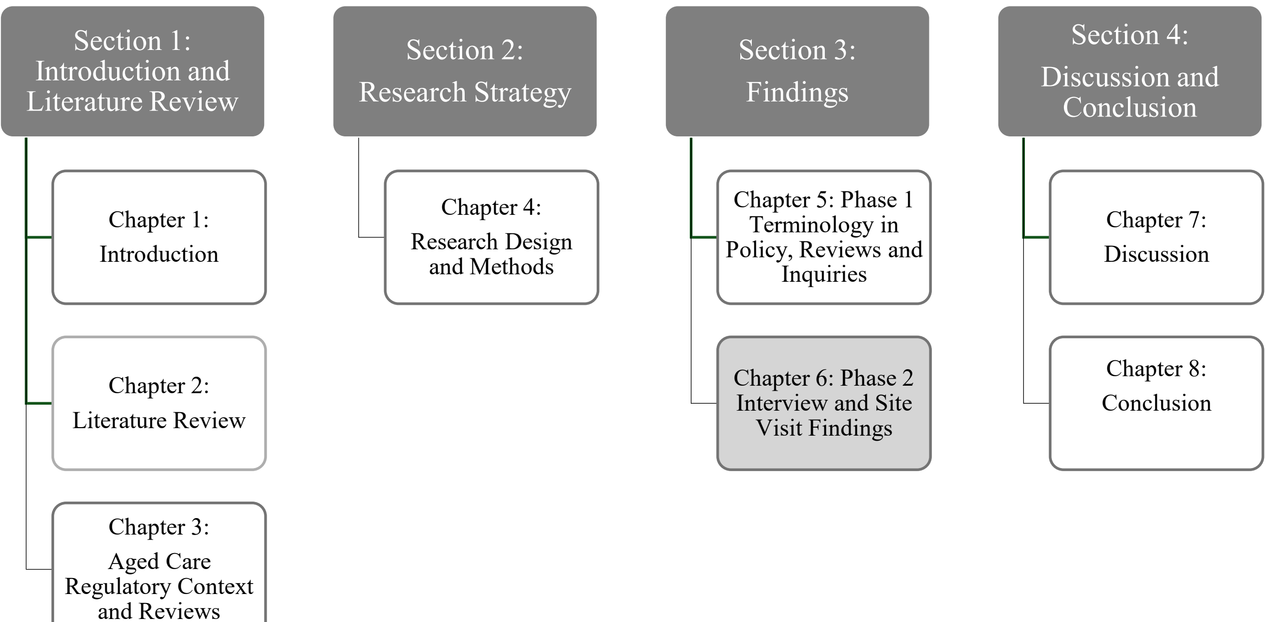


Figure 28 Thesis Outline Chapter 6

Specifically, the interview findings presented in this chapter address the remaining research questions, which were:

RQ 2 How do aged care leaders perceive the relationship between "legislative and policy terminology" and the effects of the implementation of person-centred care models on residential aged care?

RQ 3 What are the perspectives of aged care leaders with regards to implementing person-centred care models in residential aged care?

RQ 4 How can international perspectives inform our understanding of implementing person-centred care models and compare them to the Australian context?

Before presenting the findings that emerged from the interviews, this chapter gives a brief description of the interviewees and the interview guide (see Appendix 9.3), which was informed by the Phase 1 findings.

6.2 Interviewees

6.2.1 Interviewee Characteristics

There were 46 interviews conducted with Australian and international aged care executives, aged-care researchers and person-centred care model developers/consultants. The count of the interviewees' designated roles is provided in **Table 34** at the time of the interview. The designation of number of interviewees (n=x) was assigned to two or more categories where applicable.

Table 34 Designation of Interviewees

Category	**Number**
Aged Care Executive	28
Aged Care Researchers	11
Aged Care Consultant/ Facilitator	9
Aged Care Peak /Lobby Body Member	6
Aged Care Board Member	5

There were overlaps in both the national and international groups and separating them could lead to people being identified. Keeping categories at a high level was also important as some could reject the categories in which they were placed. The total across both groups was n =47, with Group 1 containing n=13 people and Group 2 containing n = 34.The interviewees came from five countries (see **Table 35**) and included 18 males

and 29 females. Some of the interviewees could be placed in more than one category so to maintain anonymity, they were categorised according to their primary role. All the interviewees were interviewed by the researcher using the ZOOM video conferencing platform because of the COVID-19. All the interviews were recorded, numbered, de-identified, categorised (according to country and primary role) and transcribed verbatim.

Within both groups were individuals who were serving or had served on many and varied international and aged care bodies, including the United Nations (UN) World Health Organisation (WHO), Leading Age, Common Age, Global Ageing Network (GAN) and the Australian peak advocacy bodies or government agencies. The interviewees reflected the provider typology of private, listed on the Australian Stock Exchange, not-for-profit or for-purpose.

Table 35 Country Representation of Interviewees

Country	**Number**
Australia	35
UK	5
USA	4
Republic South Africa	2
Canada	1

Table 36 Range of Provider Types

Range of Provider Types	**Number**
Private or Listed Provider	3
Not-for-Profit or For-Purpose Provider	18

6.2.2 Interview Guide Development

Informed by an explanatory sequential mixed methods design, the interview guide was informed by the study's objectives and the identified gaps in the literature (chapter 2) and developed (chapter 4, section 4.3) following the findings from Phase 1 (reviews and inquiry analysis, chapter 5), as well as being.

To recap, the Australian aged care sector had experienced multiple reviews and shifts in policy over the decade of 2011-2021. These reviews had focused on financial

sustainability for the aged care sector, as the number of older Australians increased and as regulatory oversight, including mandatory clinical indicators, improved. As described in chapter 5, the reviews indicated a shift in the terminology used to refer to older Australians, with terms throughout the reports such as *consumer-centred, person-centred* and *resident*. Indeed, not only was there were a multiplicity of terms, but these terms were used interchangeably in the data. As a result, several domains were identified from the Phase 1 initial analysis that necessitated deeper exploration in the Phase 2 interviews. These domains provided a focus for the interview guide development and were formulated into the semi-structured interview guide (See Appendix 9.3).

The first domain area explored in the semi-structured interviews provided an opportunity to explore attitudes and perspectives about the shifts in terminology referring to older Australians, and the primacy of the legislative pillars of regulation and funding, as they were expressed in the multiple reviews and inquiry reports. *Caring for Older Australians, 2011*, (Productivity Commission, 2011), *The Aged Care Roadmap*, (Tune, 2016), *The Legislative Review of Aged Care, 2017,* (Tune, 2017), *The Review of National Aged Care Quality Regulatory Processes, 2017,* (Carnell & Paterson, 2017) and *Neglect 2020* (Royal Commission into Aged Care Quality and Safety, 2019b).

The second domain related to implementing person-centred care. The decade of 2011-2021 had been a dynamic period in Australian aged care, with policy shifts predicated on a platform of "consumer and choice" in meeting the care needs of older Australians. Therefore, it was important to understand if and how these policy changes had prompted the interviewees to review their own person-centred models of and approaches to service delivery. The interviews also explored why and how the changes in policy settings led the implementation of person-centred care in their organisations.

The third domain explored attitudes regarding the prominence of the legislative pillars, including funding and regulation underpinning aged care and how they impacted the implementation of person-centred care models.

The opening question, "What does person-centred care mean to you?" was intended to create a generative space of inquiry regarding all the domains in the semi-structured interviews. The responses to this question are presented briefly, followed by the themes associated with the domains, as outlined above.

6.3 Site Visits

6.3.1 Site Visit Characteristics

This study was conducted against the backdrop of the COVID-19 pandemic, resulting in challenges to the planned site visits. **Table 37** provides an overview of the provider sites visited and whether they were not-for-profit (NFP) or for-profit (FP). Apart from privately listed Australian providers, all provider types were visited for this study.

Table 37 Site Visits Provider Status and Interviews Associated with Sites

Site	Site typology and status	Number of Interviews
Boronia	Small, Single Site, NFP	1
Banksia	Large, Multi-site, National NFP	1
Snow gum	Large, National FP	1
Kentia	Large, Multi-site, National NFP	2
Jacaranda	Large, Multi-site, Single State NFP	2
Frangipani	Large, Multi-site, Single State NFP	2
Flame tree	Family-Owned, Multi-site, Single State FP	1
Macadamia	Multi-site Single State NFP	2
Wattle	National FP	1

6.4 Seeing the Whole Person

The terms "person-centred" and "consumer-centred" were identified in Chapter 5 as key terms. Thus, the interviews sought to understand the perspectives of interviewees on both. A key theme in the analysis was interviewees' feelings of equivalence and ambivalence associated with the terms at an organisational level, while reflecting on the meaning of "person-centred" at a personal level.

For these leaders in aged care, their personal understanding of the term "person-centred" was about seeing the whole person, with the personalised responses to the question

eliciting responses such as "letting me be who I am, my authentic self" (International Aged Care Executive 16) or "see the person as an individual […] it's about knowing the person*"* or, as some said, "walking in their shoes" (Australian Aged Care Executive 52). To illustrate further, Participant 41 saying, "It's about how each of us would want to be treated or how we would want our parents to be treated" (Australian Aged Care Researcher 41). Participant 10 provided a personal driver and rationale to realise that delivery of person-centred care was central to realising quality of life: "Person-centred care is also known as 'life'" (Australian Aged Care Executive 10). Indeed, the responses of some of the interviewees extended this relationship further, to being more than defining the person by their illness or frailty. For example, an Australian aged care researcher said:

> It's seeing the person where they're at. Whatever that may be, with all its warts and all, it is seeing the possibilities of that person, so it's not seeing everything that's wrong with them, it's thinking, you know, and it's coming up with creative solutions. (Australian Aged Care Researcher 9)

In addition, interviewees reported that the outcomes of these perspectives were to create experiences and empower people. To illustrate, Australian Aged Care Executive 22 stated, "We create communities and experiences to enable older people to live their best lives" and linked this to make person-centred care a reality:

> Person-centred care is really about empowering the individual and empowering them to fully participate. And I guess connected to that is a belief that that's possible, irrespective of your circumstances. If that right approach is taken, then you can be empowered to participate. (Australian Aged Care Executive 22)

6.5 Equivocal and Ambivalence in Care Terminology: Person/Consumer or Relationship-Centred

In response to exploring other terms in the Phase 1 documents, such as "consumer", "client" and "person-centred", many interviewees described fatigue and a shift regarding use of the term *person-centred*. In fact, many of the interviewees said *person-centred* was overused in policy and government documents, with several stating, that it "…was thrown around a lot and fundamentally people don't know what it means" (Australian Aged Care Executive 30). Further, a number of interviewees described the term "person-centred" as

a "shibboleth"[5i], as in the quote below, and reported changing to using "relationship-centred care".

> Why is it now so politically correct to have person-centred care and it has almost become a shibboleth and I think there is a tendency for it to be a "shibboleth" that, you know, if you put it up on, put it up on the wall that you use person-centred care, then that's it you can move on to something else. (Australian Aged Care Executive 44)

Other interviewees were more forthright regarding the ubiquity of the term, "person-centred", and described that, as a consequence, the term had become vacuous, outmoded, meaningless and no longer important or relevant.

> I've gone away from "person-centred approach" to "relationship-centred approach", and why I like that concept better. I mean, for "person-centred", it's just knowing about the person, and that person knowing a little bit about me. (Australian Aged Care Academic 5)

This opening section has presented a range of interviewees' responses regarding the term "person-centred". Their perspectives pointed to a broad understanding at both a personal and organisational level. In addition, the perspectives highlighted that the term was perceived to be overused and had subsequently become irrelevant. The next section will present the perspectives of "consumer-centred care", as identified in the Phase 1 findings.

6.5.1 Perspectives Regarding the Term Consumer Centred Care

The Phase 1 analysis identified that the term *consumer* became the normative way of referring to people following the release of the *Caring for Older Australians Report* in 2011 (Productivity Commission, 2011) and that it appeared to be used interchangeably with the term *consumer*. The interviewees shared their general perception that the term "consumer-centred" appeared to be aligned with engaging with people who had choices associated with their care, which "sort of implies people have some choice and control" (Australian Aged Care Executive 06). Another interviewee agreed that while the term *consumer* supported personal agency, how to realise these personal choices and agency was a tension in practice settings, as Interviewee 9 described:

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[5] Shibboleth "a belief or custom that is not now considered as important and correct as it was in the past" *Cambridge English. (2025). Cambridge English Dictionary. In Cambridge English Dictionary. https://dictionary.cambridge.org/dictionary/english/shibboleth)*.

> There is a lot of tension. If I open up decision making to consumers, then I have to do what they want, even if it's not right for the service, or if it's, you know, unacceptable risk score. (Australian Aged Care Researcher 9)

Indeed, other interviewees questioned the utility of "consumer" and the associated concepts of "choice and control" when complex care needs or emergency situations were the dominant focus for people in residential aged care.

> So, if you have a rule that says a provider must consult with residents, now called consumers, which says we're giving them a title of consumer, as if they are consumers when they're not. They're frail vulnerable people living in an institution or within a framework. And their choices that you would normally attribute to a consumer don't exist. So, part of it [the policy intent] is in language because I'm a believer that language says everything. (Australian Aged Care Executive 10)

The range of opinions expressed about the term "consumer-centred" care highlighted a disconnect and tension faced by providers. Many interviewees said that "consumer-centred" depersonalised the individual receiving care because it connoted a transactional interaction. Many said that the term "consumer-centred care" evoked the perception that caring and practice were a commodity or product offering in residential services (rather than being predicated on relationships), as described by Interviewee 51:

> I'm not comfortable with it on some level, because I think it puts care and the delivery of care as a commodity. (International Aged Care Executive 51)

This underlined that the term "consumer" had retail connotations and hence was not a term that they, as providers, associated with their services. This perspective was echoed by 90% of the interviewees and is encapsulated in this response:

> Most people don't appreciate being referred to as a consumer because of the retail connotation that comes with it. (Australian Aged Care Executive 17)

Of the 12 overseas providers interviewed, only one used the term "customer" in their services. When questioned further, the interviewee offered the following rationale, which highlights a business or commercial aspect to service provision:

> …people were paying for services and hence, they should be referred to as customers …and it's the term we use on the website, given our breadth of services (International Aged Care Executive 54).

Most providers highlighted their ambivalence towards the terms "consumer", "client" and "resident" and said they avoided using the terms "consumer" and "client" in practice settings. The following quote describes how all these terms ("customer", "consumer", "client" and "person") can become transactional in practice settings:

> …all of them [terms] become transactional. It becomes, you know, that, that product, if you like, rather than a person, somebody who, you know, actually has thoughts and feelings. And so, I've never, never been attracted to any of those terms, and never use them in our documentation. (Australian Aged Care Executive 55)

This ambivalence and fatigue were further emphasised in internal debates in some organisations regarding the multiplicity of the terms and their interchangeability in practice:

> I'm about making sure that we always think about the "consumer" or "client", "resident", or whatever it is, endless debates about what's the best terminology, but that they're really at the centre. And it's about them. It's not about us, and trying to make them fit into, you know, our particular structures and products and services. (Australian Aged Care Executive 12)

However, for some interviewees the term "consumer" with the policy underpinnings of "choice and control" conveyed further dissonance with aged care delivery and older people.

> I'm struggling with a little bit the moment because and I know that …consumer is perhaps not the right word, because they're not really, truly, they don't really have the choice of a consumer in the way that other products are consumed. (Australian Aged Care Executive 06)

The dissonance associated with the terminology and policy was extended further by interviewee 09, with the comment, "If we call them consumers because that says okay, you're purchasing in a market but then does that devalue the actual you know, care dynamic?*"* (Australian Aged Care researcher 09). For many the dissonance, was more

akin to conflict between care delivery and the term “consumer” which were perceived as antithetical to and incongruent with care, as demonstrated by the following:

> I’m not interested in playing around with language just because it’s ok, it’s around how things work in a care home room, which is about relational care. It’s about compromise, it’s about working together so that we all have an enhanced quality of life, and this doesn’t fit with a consumer model. (International Aged Care Researcher 15)

Indeed, interviewee 16 said:

> I don’t like the word “consumer.” Although you are consumer of a service in one respect, to me it depersonalises someone. (International Aged Care Executive 16)

While there was equivocal and ambivalence about the multiplicity of the terms in use, the interviewees said that whatever term was used, the centrality of the person was uppermost:

> Person-centred care is about allowing the resident, consumer, a person that is getting the care, to have choice to be able to exercise that choice without having judgement. (Australian Aged Care Executive 15)

6.5.2 Section Summary

The equivocal and ambivalent attitudes to the terms reported by most interviewees demonstrated that, despite the shifting terminology to refer to people, the terms in use had the potential could become transactional and controlling in practice settings. Nonetheless, the centrality of the person was key to their organisational and personal approaches, regardless of the multiplicity of terms used to refer to older people. Even with such intentionality, however, the bureaucratic processes and control associated with the legislation were seen as hindering forces to the implementation of person-centred care models, as the next section shows.

6.5.3 Bureaucratic Control Perceived as a Limiting Force

The Leximancer analysis in Phase 1 highlighted that the regulatory or compliance aspects in the “care” and “provider” themes were a central aspect of aged care service provision. Furthermore, observations from the site visits for this research revealed a number of tensions associated with the expression of person-centred care in practice. It was clear at

each site that, based on public health orders from the federal and the state departments of public health providers in the states where I carried out this research were controlling and protecting residential aged care facilities. COVID-19 Rapid Antigen Testing (RAT) stations and recording sheets were available in vestibule areas prior to entry. In addition, numerous government posters promoted awareness of signs and symptoms, use of hand sanitiser and wearing masks to protect older people. Posters displaying *The Charter of Aged Care Rights*, required by the Australian Aged Care Quality and Safety Regulator, were on display in the foyers of the residential care homes, as were posters displaying information about how to escalate concerns, including phone numbers for aged care advocates, Department of Health agencies and the providers’ internal quality improvement teams.

In all the homes visited, the community areas, including coffee shops, communal family areas, mini supermarkets and hairdressers, were closed. Some were sealed off with what looked like police tape crime scene tape. Staff reported that they were unable to conduct normal activities with residents and that all the books and magazines in communal areas had had to be discarded. Indeed, these communal spaces were devoid of anything that might signify shared experiences.

These site observations provided a contextual backdrop to the interviewee responses that follow below, including the tensions they were experiencing as a result of both the immediate COVID-19 requirements but also regulation more broadly. Mealtimes were observed to be pre-plated and served to residents, even though buffet style self-service equipment was visible as I walked around. This observation was clarified with the staff who were on duty, and they stated that previous buffet options and residents being involved in food preparation had ceased because of COVID-19.

It was important for me to understand the perceptions of the interviewees about the regulatory or compliance model as they sought to implement person-centred models of care. Attitudes reported by the interviewees indicated their experience with the bureaucratic nature of regulatory processes and tensions between both providers and the various iterations of the regulator, i.e., the Aged Care Quality and Safety Commission in Australia, and the Care Quality Commission in the UK. However, the interviews did evince an overwhelming commitment to deliver a good service to older people. Indeed,

for all of those interviewed, the implementation journeys to which they were committed as providers were to enhance the lived experience of older people and to create meaningful residential aged-care communities. Yet, their perspectives saw the legislative processes as bureaucratic, and working in opposition to their intent. For many interviewees, the *Aged Care Act 1997* (Cth) reflected the financing structures of “care”.

> I think, the Aged Care Act, and I mean, I’ll stress this because I’ve just gone through with the Royal Commission, the Aged Care Act dictates a lot of the financial mechanisms that are in place, and the financial mechanisms don’t support a relationship based or a person-centred approach. Okay, they don’t, they’re misaligned. And that’s, that’s obviously a big problem. (Australian Aged Care Executive 37)

6.5.4 Bureaucracy with Regards to Regulatory Framework and Processes

Overwhelmingly, attitudes towards the regulatory models in all the countries represented by the interviewees suggested that they understood the role and purpose of the regulatory standards.

> I think it is very important that people are safe. And that standards are maintained. And regulatory framework is part of that… an essential part of it. The idea that you can hold your organisation up to the standards that society sets is really important. (International Aged Care Executive 12)

Indeed, they all accepted the necessity of external assessment with regards to delivering quality aged care, as indicated by the following:

> It’s the right focus, because we’re coming back to what should be driving the whole system, which is the lived experience of those elders. (Australian Aged Care Executive 38)

Further, Interviewee 17 understood the rationale for changing the regulatory model to support “consumer” and “choice”:

> The standards, I agree, pick up customer and consumer. To me they are interchangeable because at the end of the day, they’re outcome-focused, they are the lens through what is the approved providers obligation, so they’re couched in terms of what must be delivered in order to be an approved provider. (Australian Aged Care Executive 17)

However, interviewees consistently noted the onerous compliance and bureaucratic nature of regulatory processes in every country, observing that these often undermined, and, indeed, for many, detracted from person-centred care implementation. An Australian executive stated, “What you get with a regulatory driven model is people comply with the forms and structures.” (Australian Aged Care Executive 45)

While the US and UK interviewees shared similar concerns regarding their respective regulatory models and processes of inspection, they also shared examples of how they attempted to educate regulators by inviting them to training sessions or presentations about the person-centred model, its design and approaches. These sessions were conducted as part of a wider awareness or orientation program to the new of PCC model for all stakeholders to ameliorate the inherent biases and traditional expectations of the surveying teams. Indeed, some of interviewees shared that they had been advised to work with the regulators before commencing their model implementation.

Yet, the overwhelming sentiment from all the interviews was that the regulatory processes (in all the countries represented) went through cycles, depending on the media and political imperatives at the time. While the role of the regulator was understood and indeed valued, the interviewees spoke about how these cycles ranged from supportive through to adversarial in their approach to residential care settings, as so aptly stated by interviewee 09:

> There’s a tension between the commission and providers. Providers being anxious about, you know that assessors are there to catch you out or, like, you know that there’s this anxiety about assessment visits. (Australian Aged Care Researcher 09)

While this sentiment may have been reflective of timing (due to the then on-going Royal Commission in Australia), some of the Australian providers went further regarding this point of tension and fear, citing numerous examples where staff were terrified of the visits from the regulator, which resulted in staff focusing more on the compliance than on the care they were providing.

> No one is working with the regulator at the moment because you’re just going to get beaten up and you don’t know why you are getting beaten up either. (Australian Aged Care Executive 44)

> A new CEO reported hearing, on visits to their sites, "I heard stories, literally of care workers running and hiding in cupboards, so they wouldn't have to speak to the regulator. This how bad it was." (Australian Aged Care Executive 22)

Furthermore, a number of interviewees described an adversarial approach to regulation, while still understanding the role of the regulator: *"*There needs to be some checks and balances that do protect people but at the moment it's all just big stick stuff" (Australian Aged Care Executive 18). Interviewees also described how the manner of the regulator impacted morale and the implementation of their person-centred model in the service:

> They decided to be absolutely heartless in their approach, and how they would find fault in just about anything, nobody was safe, and it caused a massive drop in morale and a huge amount of unnecessary work. It took us a long time to get over that. (Australian Aged Care Executive 42)

This heightened regulatory approach towards protecting the safety of residents and the processes by which the regulatory levers were being applied are reflected in this quote from an executive with considerable tenure in the sector:

> The sector overall is still being influenced by the regulatory lever and the regulatory lever, let's be real, in the last two years has been a very heavy hand. We've seen more sanctions than in the history of my 30 years in the industry. So, you want to get the attention of people, you get their attention when you stop their ability to take admissions, make statutory appointments, which are expensive, and institute a training plan. The regulator is saying, you have to change, and you have to change by a certain timeframe, otherwise, you're not going to be an approved provider. (Australian Aged Care Executive 17)

6.5.5 Bureaucracy with Regards to the Funding Model -(Funding Model: Tick Boxes and Time Wasters)

Similar to the regulatory and compliance pillars, the funding model was perceived as a bureaucratic process. The terminology, documentation and auditing processes required to show care required nursing staff to spend extra time completing tick box forms or additional paperwork, which removed them from the processes of care, providing emotional support and delivering person-centred models. For many of the interviewees, these bureaucratic processes detracted from the essence and right to quality of life:

> You don't come here to die, you come here to live … and as long as your heart is beating you are living … so where is psychological and psychosocial health in the funding model? It's all left out. (Australian Aged Care Executive 49)

Although interviewees acknowledged the need for forms and audits to prevent fraudulent claims and funding maximisation, the excessive bureaucratic processes nonetheless intensified tensions between the regulatory bodies and healthcare providers.

> We have this crazy ACFI system which means our registered nurses and carers are pulled away from our residents to fill in forms and tick boxes. Then we get audited. So, people come and take the money off us. It's the most demoralising system that there ever is. (Australian Aged Care Executive 35)

The funding mechanisms were deemed by a number of interviewees to work as a barrier to person-centred care implementation, and for two reasons. They were deemed to be bureaucratic and unintentionally led to categorising people with dehumanising terminology. This leads to the next theme identified from the interviews, namely, competing tensions and policy perversity.

6.5.6 Section Conclusion

Overall, the interviewees' responses regarding legislative pillars, regulation, compliance and funding in each country indicated that while the intent behind these elements was understood, the forms and activities associated with these bureaucratic processes appeared to take precedence for regulatory agencies over actual care delivery. Collectively, these pillars served to hinder the implementation of person-centred care.

6.6 Competing Tensions and Policy Perversity

The third theme that was identified from the interviews was competing tensions regarding legislative underpinnings and realising the goal of person-centredness in practice. While interviewees acknowledged the primacy of the person, they identified many tensions between policy and protecting older people. They said they were conflicted about the need for supporting autonomy and choice and their responsibility with government legislation and the decision-making capacity of the person being cared for, for example:

> It's really difficult because if you're going to be truly person-centred, that actually the decision-making and autonomy should be in the person but, you know, working with these very vulnerable groups, and I always was feel conflicted saying that oh, they're the person, you know, they have personhood and they can make their own decisions. But there is something about, and I come from a position where I think the state has a responsibility to regulate and safeguard. (International Aged Care Researcher 26)

However, other responses indicated different tensions between the intent of the policies and how they were operationalised by the various agencies. The responses showed a perception of inherent dissonance and the policy rhetoric of "choice and control" for older people with regards to their personal autonomy and choices. In fact, aspects of ageist bias or tension were reflected in all the interviews. Interviewee 38 stated their antipathy to the policy positions thus:

> Labels create "Other", then you become less than and therefore not contributing to society. (International Aged Care Executive 38)

In addition, there was a desire to challenge the structural policy settings that were perceived to perpetuate these biases and tensions:

> They're not vulnerable; we create these boxes of bias, and they're (older people) in a box of bias. Looking at what are those policies that sustain the bias that create the box? Because we all know that there are policies that create a box of bias? (International Aged Care Researcher 22)

6.6.1 Tensions and The Aged Care Act 1997 (Cth) (the Act)

A particular point of contention was the Australian *Aged Care Act 1997*, which was regarded as outdated and paternalistic, "It's paternalistic in its nature" (Australian Aged Care Executive 10). Other comments regarding the *Aged Care Act 1997* reflected the length of service and involvement in the sector of some interviewees. For instance, several Australian interviewees who had been involved in the sector since the development of the *Aged Care Act 1997* provided such insights as:

> It wasn't designed in the interests of the older person, the person receiving the care. It was designed to meet the needs of a regulator, and a funder, and providers who needed to tap into that system. (Australian Aged Care Executive 22)

While the quotes above were indicative of paternalism associated with the *Aged Care Act, 1997 (*Cth*)*, other interviewees extended this sentiment and pointed to the origins of aged care based on a welfare model and structural biases regarding older people and the lack of human rights within the *Aged Care Act, 1997 (*Cth*)*. People stated that the Act had been constructed for an older person to receive care based on luck and good fortune. Human rights were not a consideration, reflecting the inherent paternalism, as Australian Aged Care Executive 55 said:

> Twenty to twenty-five years ago, years ago, when it was first being written up, …, that's how aged care was considered, it really was, you know, and it was almost like, well, you're lucky to, to be given, you know, care. And if you got great care, you were even luckier, whereas that attitude has not been around in our community for many years. And the Act hasn't caught up with it. (Australian Aged Care Executive 55)

These structural biases towards older people were not unique to Australia; they were also reflected in the UK interviewee responses. Since many of the interviewees had been involved in various iterations of legislation, they highlighted the need to understand the history of how aged care had evolved and thus understand the perceptions of older people in policy. Moreover, the interviewees went further, saying it was obvious that the approaches to policy development were about how to contain cost or to "manage the financial risk of government" (Australian Aged Care Executive 49). Paradoxically, despite the policy position of "choice and control" for older people, "Overall it's about economic stringency, not humanistic approaches" (International Aged Care Researcher 6). Lived experiences and caring relationships were downplayed, as the prevailing concern was the government budget. Aged care service provision was considered less important than other social service expenditure because of the perception that older people were no longer of value.

> And yes, I mean, you know, things like human rights weren't taken into consideration, because older people were seen as unfortunately, not having as much value as they did when they were younger. (Australian Aged Care Executive 55)

The responses also highlighted tensions between other government social services. Interviewees cited the differences and frustrations in the funding allocation across various social service offerings, such as childcare, disability and even veterinary costs were mentioned by way of comparison!

The systemic challenge associated with the legislative aspects of aged care and the implementation of person-care model were misaligned and caused tension for many providers. The following quote reveals this tension, as the interviewee worked in the wider legislative framework to support older people and deliver person-centred care:

> But you can also go beyond the Aged Care Act, because your industrial instruments are also, they're not fully aligned to supporting a person-centred approach to care as well as some challenges with the industrial instruments as well. (Australian Aged Care Executive 37)

6.6.2 Tensions and the Regulatory Framework -Safety vs Personal Choice

All the interviewees questioned whether the regulatory standards and processes truly supported the realisation of personal choice in practice. This disconnect was based on the tensions of primacy of safety for people overriding personal choice:

> And then regulation is all about safety versus choice, you know, regulation. We have things in place now interpretive guidelines that talk about person-centred care, but to what extent are those being, you know, again, actually integrated into the survey system. (International Aged Care Researcher 34).

In all the interviews, food was used as a practical example of the bias associated with the inherent tensions of choice and the regulatory models:

> When it talks about in the standards of aged care, weight loss as being one of the benchmarks around substandard care. To me, weight is personal and reflects people enjoy eating. If they have 10 ice creams a day that's their choice. But under the regulatory model, they would define that as substandard care, someone was having non-nutritional meals. Now, if you in your own home today want to eat 10 ice creams today, no one comes in and tells you that that's not okay. But for some reason, as soon as the government is subsidising your care, all of a sudden it becomes a very granny type of grandparenting approach of "I'm going to tell you what's okay and what's not". (Australian Aged Care Executive 15)

Another practical example of the desire to select a favourite food and to enjoy that choice is the requirement for liability waivers based on the assessed risk and primacy of safety when in residential care versus when in one's own home:

> We have our own desires and needs and if I want to have [sic] expose myself to risk like having a hamburger or pizza, even though maybe I have a swallowing challenge, why can't I do that? So, we we've kind of challenged things like for example, for food. It could be it seems silly, but we might need a release of responsibility that I'm willing to accept a certain amount of risk and for my dignity so I can have that hamburger even though I might have, I might aspirate, I'm going to take that risk. (International Aged Care Executive 08)

These tensions created organisational risk management challenges for providers, who had determined what their organisational risk appetite was regarding older people having the right to choose. This tension was an interesting aspect and acknowledgement that it is the person themselves who determines what matters to them. This tension once again connected back to terminology and language:

> …by calling them consumer I don't think they've really addressed the consumer rights issue. Yes, you've got the standards and yes, you've got the things that they sign up to, but I don't know if anybody's really tested because of the funding and regulation etc.…. So, are they really consumers? (International Aged Care Executive 51)

The interviewees stated that from their perspective, person-centredness enabled quality of life and the lived experience in residential care. This was not life experience measured by others; it was to be their own measure of life experience with supported decision making.

> The wording is dignity of choice. For some people might take it to quality, safety, risk, compliance, where I take it is where can we push the boundary to allow multiple and multi- dimensional conversations of choice for different people, because it means different things to different people. (Australian Aged Care Executive 10)

6.6.3 Tensions and the Funding Model for Residential Aged Care -Funding Model vs Person-Centredness

Other interviewees found the language used to differentiate and categorise older people and their needs in the policy settings, especially the funding models, worked against implementing person-centred care models: "It's not a care centred person-centred tool" (Australian Aged Care Executive 38).

The funding model for Australian residential aged care uses a classification system to determine the level of government funding for services based on the care needs of individual residents. The tool was perceived to be a biomedical model focused on the clinical issues of the person and from a deficit perspective. In essence, the higher the classification for an older person, associated with the tool the greater the funding from government to the provider. All the Australian interviewees talked about how the funding system disincentivised reablement and a number referred to the funding tool as promoting disability.

> The model here is very much one that rewards disability, not ability and doesn’t recognise that there are stages of life. You may have one or two more long-term conditions, but that doesn’t stop you living a meaningful and worthwhile life. And so, when you’ve got that, you’ve got that wrangle between staff having to capture everything from a negative perspective in order to release the appropriate level of funding. But what you want your staff to actually do is enable people to live the best life possible. (Australian Aged Care Executive 51)

Furthermore, the deficit biomedical model was seen to reward health deterioration and that “making” someone as sick as possible resulted in enhanced funding to support care provision. It was also criticised as not being fit for purpose with regards to funding and supporting the social aspects of residential aged care, an essential component of person-centred care models.

> So, if I have, you know, had a fall, break my hip, all of a sudden, I’m immobile, I can be brought back from that, you know, I can be encouraged, I can be provided with a rehabilitation program, and I can become, quite fairly independent again. But if you put me in an aged care facility, and that aged care facility receives more funding for me, because I’m immobile, what do you think is going to happen? And unfortunately, that’s what happens. (Australian Aged Care Executive 55)

The funding mechanisms were deemed by a number of interviewees as barriers to person-centred care implementation. The funding model was deemed to be bureaucratic and one that unintentionally led to dehumanising terminology to categorise people.

The interviewees perceived the funding model to be lacking in humanity. Indeed, some interviewees extended this, stating that the funding model was associated with the

structural issues in aged care i.e. that labelling people based on their funding categories achieved greater funding.

> I think what happens is when people enter residential aged care, they cease to become a person, they become other, and the system, others them, and the policies and practice others them. (Australian Aged Care Researcher 09)

Further, the process of completing funding forms was seen to perpetuate a perverse system of classification based on individuals' care needs, support requirements and their ability to perform activities of daily living, which results in what one interviewee aptly called a "box of bias" (International Aged Care Researcher 22), meaning the association between negative terms and stereotyping inherent in completing forms. Sadly, interviewees recognised how these terms and classifications needed to justify funding became the terms with which people were referred to in practice.

6.6.4 Section Conclusion

These previous sections (6.6) have focused on the perspectives of the interviewees regarding the terminology in the legislative pillars and reviews of aged care as they pertain to the implementation of person-centred models. They have also highlighted how the legislative pillars are interpreted and experienced by providers when implementing person-centred care models in practice settings This section has highlighted the policy to PCC model and practice tensions that exist. These qualitative perceptions provide insights into the quantitative aspects of the study and underscore the importance of a mixed methods design for the study.

6.7 Processes of Implementing Person-Centred Care

The previous themes have elicited perceptions and perspectives of the interviewees relating to the conceptualisation-of-care terminology in policy, including "consumer" "person" and "client", and the terminology from an external or government policy standpoint as it related to implementing person-centred models. This last theme relates to the organisational processes of implementing person-centred care, the internal approaches that have underpinned implementation in practice settings. Four sub-themes emerged from the analyses of these responses, as follows:

1. Motivation for implementing person-centred models or the case for change

2. Leadership to support the implementation of person-centred care models
3. Change processes to support the implementation of person-centred care models, and
4. Practice change and organisational alignment in person-centred care implementation.

6.7.1 Motivation for Implementing Person-Centred Models or the Case for Change

Against the background of a dynamic policy environment and shifts to "consumer and choice" in the Leximancer analysis (see Chapter 5), these interviews sought to determine whether external policy dynamics motivated providers to review their model of care and implement person-centred care models.

The responses were varied. Several interviewees said the rationale for changing or enhancing their model of care was a consequence of a critical adverse event or failure, which were seen as watershed moments, both for the interviewees and their organisations. For others, repeated issues or patterns that generated complaints and/or negative feedback led to a very strong belief that the status quo could not be maintained in light of the policy shifts that were being foreshadowed.

> The cold reality of it is, when you're responsible for the lives of people, that should change your thinking and responsibility. Not just the quality of life. That's part of it. But the actual lives. So, they've got to be thinking … is … how do we deliver our services in a way that the person wants? That's what person- centred care's about, you always end up back at that spot. (Australian Aged Care Executive 10)

For others, it was seen as a foundational step in the change process and/or a reappreciation of the purpose and mission of the organisation in a contemporary context; put simply, it was their "organisational why?" For other interviewees, the delivery and enhancement of their person-centred model of care was described as innate, arising from their intrinsic personal motivation and reflective of their organisation's mission and values:

> I think person-centred care or valuing the person, and the human dignity of individuals, is completely core as to who we are as an organisation. (Australian Aged Care Executive 22).

This alignment of personal and organisational values was a critical factor in guiding and grounding the implementation of person-centred care.

> It really all started for us with a question of mission. But it came down to a question of whether or not we were truly enriching the lives of older adults in doing that, or were we just providing good medical care? And so, we kind of challenged ourselves with that question, is there more we could be doing to actually enrich the lives of the people who lived there, instead of just treating them as the recipients of care? (International Aged Care Executive 38)

In addition to mission alignment were interviewee perspectives associated with organisational values. Exploring this aspect of how the values of the organisation and the values of person-centred care were translated and codified highlighted the intentionality and intrinsic motivation of many interviewees. They were aware that person centred care this step was foundational. For many interviewees, the overriding first step in evaluating their current model of care started with reviewing the values of their organisation and questioning if those values adequately expressed what was required to underpin the person-centred model they hoped to achieve.

> We’ve done a lot of talking about this, to be honest. That was the start of the journey. (Australian Aged Care Executive 22)

They were aware that as an organisation, to implement a PCC model and be to be successful, they had to review their values, otherwise implementing PCC was considered tokenistic:

> Focusing on the model is something providers do without establishing what the basic sort of value set is around person-centeredness. (Aged Care Researcher 26)

This underscored that implementation requires deep work and alignment to cultural values.

6.7.2 Critical Importance of Person-Centred Leadership

All respondents mentioned the critical importance of leadership at all levels of their organisations, large or small, for the implementation to be effective, including the role of boards and executive teams to bring about the change required.

> I think it’s got to be absolute commitment from the board because it has to be properly resourced. And if it’s just a commitment that goes as far as “This is in our strategic plan, and these are the words we use” and it doesn’t extend to the budget, it’s not going to work, in my opinion. So, it’s got to be an absolute commitment from the board. (Australian Aged Care Researcher 09)

Interviewee 09 highlighted the need for both executive verbal and financial support for person-centred implementation, stressing that endorsement from executive leadership teams was crucial for aligning budgetary structures with the implementation process. The centrality of the financial and budgetary commitment and allocation to the implementation process cascaded through the organisation to for accountability.

> But I think the most important thing to the board is to make it a priority. And to ensure that management knows it’s an expectation and thirdly is that it gets the priority and funding and focus that it needs. (Australian Aged Care Executive 40*)*

The type of leadership support the respondents wanted was not just tacit support. They considered that both financial commitment and appreciation of the change were essential. Indeed, in many cases this commitment was evidenced by board members and executives participating and experiencing the training or the service from an experiential perspective.

> I wanted to make sure that from our governance down … effectively for my board, I make sure that they get good immersion experiences. So, they have to spend [time], that is, they have to arrive no later than four p.m., eat the evening meal, sleep in a bed. And they can’t leave until after breakfast, and they’re not there to conduct an audit. They don’t take a clipboard. There’s not a reception for them, they’re not giving the tour, know what I mean? They’re not treated as that. So, their job is to be immersed. (Australian Aged Care Executive 4)

6.7.3 Aligned Change Processes to Support The Implantation Of Person-Centred Care

While the alignment from board to bedside was considered essential, equally important were the values and the style of leadership modelled by the senior leadership teams. These were reported as critical to nurture and support the ongoing process of implementation.

> In really getting back to the fundamentals of what we’re all about, and we looked for values, and we discussed long and hard, what should be the value words of our organisation … I would speak to them about the values of the organisation, and I would

> concentrate on those four words, and everybody got it. And so, in a sense, that was how we formed created that cultural platform. (Australian Aged Care Executive 7)

All the interviewees agreed that co-design and collaboration, or capacity building, for front-line engagement were essential in the change journey. Notably, they said that collaboration and codesign were also essential for the people using or living in the services, and that their families needed to be involved in the change process:

> Let's not again sit in a room and all decide, you know, as professionals, to decide that we're changing. This is going to be co-constructed with the people together but it's also about … not just for [what] the resident is called … it's also what the staff are called and what the relatives are called. It's about everybody. (International Thought Leader 5)

6.7.4 Practice Change and Organisational Alignment to Support the Implementation of Person-Centred Care

In addition to leadership, the interviewees wanted the whole organisation, from typical support services through to the front line, to change.

> So, you know, the finance people and, and so on, and board members and people from maintenance, and so that it was it was deeply spread through the organisation. (Australian Aged Care Executive 7)

The organisational alignment and commitment required for the change implementation is was demonstrated by the following:

> So, it's no good just for your nursing service manager to decide, okay, we're going on this transformation journey, if the manager of the home is not on board, if the board is not on board, so it's really about everyone being on the same page. (International Executive and Thought Leader 2)

6.7.5 The Clinical and Work Culture Must Be Integrated

Overwhelmingly, the interviewees believed from their experience that implementing person-centred care in residential aged care homes needed to be led on a day-to-day basis by front-line teams. They felt that operations teams could best communicate the change and how it would link with the service delivery. While agreeing about operations/service delivery, other interviewees said the implementation needed to be integrated across the organisation.

While there was general agreement on the need for alignment across an organisation, there were interesting responses regarding the change implementation being led by human resources (HR) departments:

> It’s … so, the answer is … it’s not driven by HR. They’re probably the worst people to drive anything. And the site managers don’t listen to them anyway. (Australian Board Member and Executive Leader 10)

In probing these responses, organisational alignment, however, was the overriding sentiment:

> It’s got to come out of operations. But it’s got to be supported by HR, and the HR function. And it’s got to be so. HR, they need to have done the training as well. But … so, they need to be prepared. They need to walk the talk, understand the vision of the organisation and what it is they’re trying to achieve. (Australian Thought Leader 2)

The support required from HR related to the wider staff capability and competencies needed to support the implementation. Coaching and leadership support for the change at the front line were reported as essential, given the competing demands on service managers, particularly in Australia with the Royal Commission into Aged Care Safety and Quality occurring in parallel with this study.

> I do think that it also happens in residential … that you will come across managers who don’t get it and aren’t in the same space philosophically as some of the staff or are so overwhelmed with all the other stuff going on … the changes to service models, you know, now the royal commission, you know, not wanting to end up on bloody 7.30 Report or something. And you know, there is so much pressure on managers as well that they don’t necessarily see the connect between prioritising empowering staff to work to change how things are done and the positive outcomes they’re actually looking for. (Australian Aged Care Researcher 9)

Finally, several responses linked back to the rationale for the change and leadership to support implementation, highlighting that the change was to enhance relationships between staff and residents in the services in alignment with the organisation’s values, as below:

> To me it's empowering our staff to do the best they can to build a relationship with that person so that life has meaning for the resident and for the staff. (Australian Aged Care Executive 3)

> So that comes back to our fundamental values, and again, we feel as … if the relationships are meaningful and positive, then everything else can be built from that. (Australian Board Member and Executive Leader 17)

This analysis has demonstrated that the interviewees knew how to implement person-centred models. They emphasised that the whole organisation, particularly the operational teams, had to be involved in and committed to the implementation process to achieve enhanced quality of life and experience of care for residents and their families.

6.7.6 Chapter Conclusion

Further to the intent of explanatory sequential mixed-methods design, this chapter has presented the findings from interviews about the three domains based on the findings from Phase 1. First, it explored the interviewees' perspectives about the shifting terminology for people ("consumer", "resident", "customer" and "person") in the reviews and inquiries. Second, it explored the interviewees' perspectives about the influence of policy and legislative terminology on the implementation of person-care models. Finally, it explored the interviewees' perspectives about the prominence of the legislative pillars, including the influence of the financing and/or funding mechanisms and regulatory processes in implementing person-centred models.

The interviews with the 46 international and national aged care executives, researchers and person-centred model designers and facilitators produced four themes: (1) equivocal and ambivalence regarding care terminology, specifically, person-centred, consumer or relationship-centred; (2) bureaucratic control; (3) competing tensions and perversity, and (4) the need for alignment, plus the need for intrinsic organisational leadership to motivate and lead PCC implementation. There was also the need for financial and budgetary support for accountability and transparency.

These findings underscored that implementing person-centred care requires a whole-of-organisation approach that involves people in practice contexts, including residents and their families. The findings also highlight the importance of involving the regulatory

agencies in the implementation of person-centred models to reduce dissonance when they undertake compliance and regulatory visits.

Overwhelmingly, this phase of the research demonstrates the resounding support of all the interviewees for an aged care sector that honours the older person, and their shared hope for a sector where person-centred care is a reality in practice. There was a clear understanding of how to implement person-centred care models, with appropriate organisational supports. An important insight that emerged was the challenge posed by the terminology and processes associated with legislative frameworks, regardless of the country, in implementing person-centred care.

The following chapter examines the meta-inferences resulting from the integration of the sequential explanatory mixed-method design employed in this study, Phase 1 terminology in policy, reviews and inquiries and Phase 2 Interviews and the study’s primary objectives.

SECTION 4 – DISCUSSION AND CONCLUSION

7. DISCUSSION

7.1 Introduction

> *There's no such thing as the voiceless. There are only the deliberately silenced or the preferably unheard. (Arundhati Roy, 2004)*

The main aim of this study was to better understand how language and terminology used in government policy influence the implementation of person-centred care models in Australian residential aged care. This chapter brings together the key insights and the meta-inferences resulting from the integration and joint display of the Phase 1 review and Leximancer analysis and the Phase 2 interviews (see Appendix 9.6).and discusses them in light of the existing literature. In explanatory sequential mixed-methods research and social theory, meta-inferences refer to the interpretations or conclusions that result from integrating or triangulating the different data sources, theoretical frameworks and/or perspectives (see Chapter 4, section 4.8) (Creswell, 2013; Younas et al., 2020).

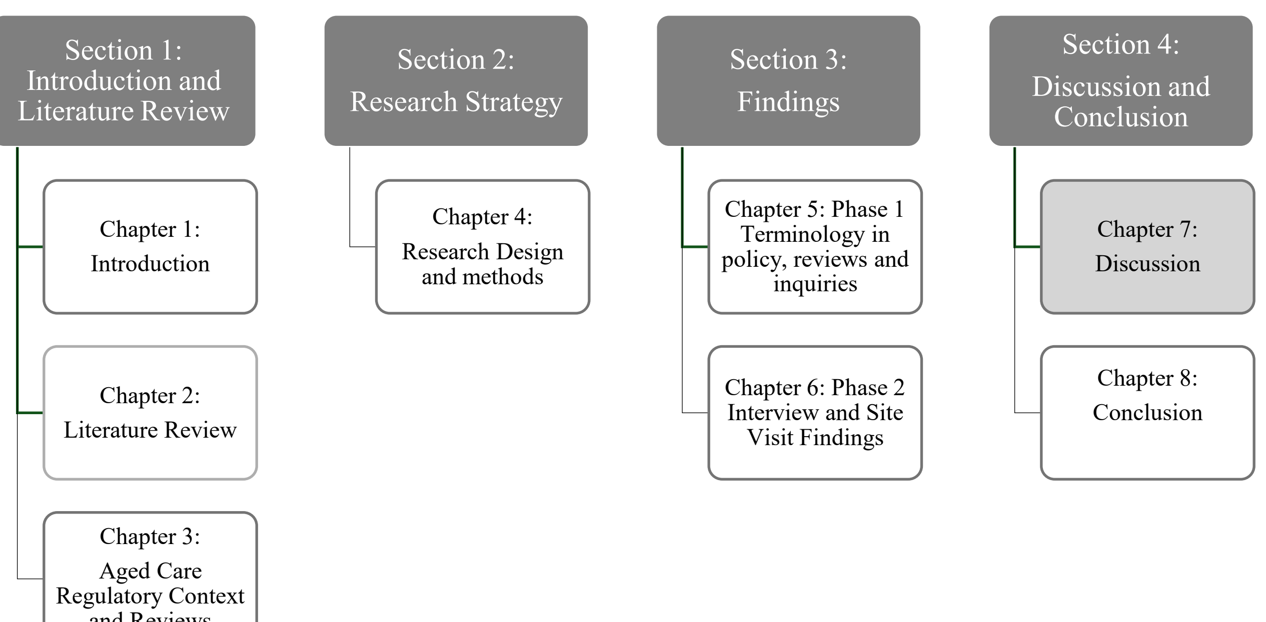

Figure 29 Thesis Outline, Highlighting Chapter 7

The meta-inferences are discussed in relation to the earlier chapters of this study, the literature review (Chapter 2) and the Australian regulatory context (Chapter 3) and then explained using a Bourdesian analytical framework through an abductive approach.

The Leximancer analysis in Phase 1 of the study (Chapter 5) demonstrated the prevalence of the Australian legislative pillars that manage and regulate all aspects of the aged care sector, as per the "care" themes (in the red circles), rather than such new terms as "consumer" and "choice" This dominance of the legislative pillars was a surprising finding, when the rhetoric of the major policy shifts was towards "consumer-centred care" with choice as a central tenet (*Aged Care (Living Longer Living Better) Act* (Cth.), *2013;* Productivity Commission, 2011; Tune, 2016, 2017). Chapter 3 demonstrated this move to a more consumer-centred approach and market mechanisms. According to the *Aged Care Roadmap* (Tune, 2016), and the *Legislative Review of Aged Care*, (Tune, 2017) the "consumer" was to determine quality and assist with "regulating" the market (Tune, 2017) (Chapter 5, sections 1, 4, 5 and 6). Yet all the providers interviewed for this research stated that the legislative pillars that governed residential aged care remained dominant, irrespective of their country (Chapter 6, section 5). Indeed, the approach and enactment of these legislative pillars by the respective government agency or department was deemed to be adversarial and punitive.

Regarding the perspectives of how the terminology of the legislative pillars and policy influenced the implementation of person-centred care (PCC) models (Research Question 2), the Phase 2 interviews with provider executives, academics and model developers shed light on the way the language translated into practice settings and the interview data into multiple tensions and paradoxes (Chapter 6, Section 6).

Notably, these tensions related to the legislative obligations, perversity and deficit language associated with funding, and the adversarial nature and risk-based approaches with regards to the regulatory processes (Chapter 6, sections 5 and 6). Both these phases led to the meta-inferences that follow.

The meta-inferences associated with these tensions relate to a legislative power dynamic for providers which influenced the implementation of PCC models of care. Language and power–"words make worlds"–and the power associated with these terms flows through organisations to the context of practice, as encapsulated by the quote from the interviewee

(international researcher 15). However, the lived experience for those in residential care, associated with the policy intent of "choice and control" was very different, as evidenced by Merle Mitchell's opening comments in Chapter 1, section 1. This power dynamic was experienced both implicitly and explicitly by staff and residents in practice settings and had consequences in the implementation of PCC, which led to the second meta-inference of language and symbolic power, the "box of bias".

The "words make worlds" and the "box of bias" were identified through the Nvivo analysis presented earlier (Chapter 6, sections 5 and 6). While "words make worlds" is associated with Rabbi Joshua Heschel (Heschel, 1996), it was initially shared by International Aged Care Academic 15. "Box of bias" was stated by International Aged Care Academic 22. Both terms were reflected by others in the interviewee analysis.

7.2 Language and Power - "Words Make Worlds"

The power dynamics associated with language generally and terminology in particular in policy conveyed through both the legislative pillars and through providers, shaping practice settings that created a dynamic that an interviewee so aptly captured when quoting "Words make worlds". This sentence underscores how this meta-inference from the power dynamics associated with government policy permeates the legislative frameworks through the requirements of the regulatory agencies and goes on to influence practice environments. **Table 38** illustrates how these power dynamics manifest both explicitly and implicitly.

"Customer" and "person-centred" (Chapter 3.10) were the accepted terms across the legislative pillars associated with Australian aged care from 2013 onwards and were enshrined in the *Aged Care (Living Longer Living Better) Act 2013* (Cth) an amendment to the *Aged Care Act*, *1997* (Cth). While these terms were enshrined in law and accepted, it was the legislative pillars which held significant influence in the reviews of aged care, and this seemed to be in direct conflict with the proposed shift towards a more consumer-centred approach and market mechanisms (Chapter 3). Further, the initial reviews led by David Tune, *The Aged Care Roadmap* (Tune, 2016) and *The Legislative Review* of Aged Care 2017 (Tune, 2017) were explicit in stating that "consumers" were responsible for determining quality and assisting in "regulating" the market (Tune, 2017, p. 52).

Despite this, the perspectives of the providers interviewed for this research highlighted their dislike and ambivalence associated with these terms and that they were antithetical to care (Chapter 6 section 5.1). In addition, the terms themselves lacked sufficient clarity and definitional specificity, despite forming the foundations of new policy (Sturmberg & Gainsford, 2019). This affirms the claims in other national contexts, such as Ireland, where the "official" versions of person-centred care are seen to focus predominantly on offering service users more choice and promoting independence, rather than emphasising partnership and a compassionate, respectful model of care (O'Dwyer, 2013).

Furthermore, interviewees were also sceptical about the rationale for shifting the terminology to "consumer", which was perceived to be driven by the government's macro-economic policy to address Budget challenges rather than to support individuals' choice and autonomy. However, some witness statements provided to the RCACQS viewed the outcome as an inevitable result of the power dynamics involved, as highlighted by the following:

> The word is now more frequently used in the sector, and we are seeing an increase in the view that people are consumers. However, this shift has occurred because the funding environment dictated it, and the external market has driven a lot of that change. This has been a shift for providers and staff that have traditionally worked in a closed traditional social community model. (Joanne Toohey, 2019, p. 13)

More surprising though was the broader meta-inference of power and language in capturing the notion that "words create worlds"–and how it related to the implementation of person-centred models. The depth of feeling and the power dynamics in the interviewees were palpable and are illustrated in the comments listed in **Table 38**. The legislative framework and the explicit and implicit power embedded in policy positions, evident in key comments, demonstrate a cascading effect that permeated throughout the aged care sector. This influence often challenges, and at times directly contradicts, the intended implementation of person-centred care models (Petriwskyj et al., 2014; Petriwskyj, Gibson, et al., 2015a). As a result, providers appear to be both obligated and constrained by the very legislation intended to support quality care, creating a tension that privileges compliance over PCC model innovation (Petriwskyj, Gibson, et al., 2015b; Sturmberg & Gainsford, 2024). These dynamics are further explored later in section 7.5.4 in relation to the exercise of government power.

Table 38 Legislative Pillars and Power

Legislative Pillar/Policy	Explicit Power	Implicit Power	Example Quote
Funding	Financing, i.e., ACFI formula	Categorisation based on funding model	• "I'm not the shower and I'm not the feed, you know, I'm not the dementia, you know, I'm Maisie or whoever I am."(Aged Care Executive 32)
Regulation	The Australian Regulatory Standards/ Rules	Posture of the regulator and assessors while on site in residential care	• "Big stick approach" (Aged Care Executive 35) • "Why do you need jack booting accreditors coming in with a hermeneutic of suspicion?"(Aged Care Executive 45) • "Absolutely heartless in their approach"(Aged Care Executive 42) • "The way the regulator speaks" (Aged Care Executive 100) • "The regulatory model where providers find themselves in a situation of being more afraid of the regulator is not one that drives quality." (Aged Care Executive 12)
	Risk-based regulation/ documentation	Forms and tick boxes	• "the tick-box mentality" (Aged Care Executive 18) • "We have a set of standards to say this is driven by the residents but in truth it's not, it's driven by the paperwork, ticking the boxes."(Aged Care Executive 12)
Consumer Choice	Allocation quotas Funding Formulae Approval processes Co-payment	Assessments, MyAgedCare portal	• "The word [consumer] is now more frequently used in the sector, and we are seeing an increase in the view that people are consumers. However, this shift has occurred because the funding environment dictated it, and the external market has driven a lot of that change. This has been a shift for providers and staff that have traditionally worked in a closed traditional social community model." (Aged Care Executive 37)

This power rooted in the authority of legislation and enshrined in the regulatory framework reflects the government's control or *symbolic power* over the sector. This control appears to be a point of tension between the business aspects of financing and regulation versus the prevailing rhetoric of consumer choice. Australia is not alone in experiencing this phenomenon; all the interviewees reported onerous requirements associated with documentation, forms and ticking boxes to comply with the business

aspects of care within the legislation. These forms reinforce power, as do the forms that assign labels to people, leading Interviewee 26 to state:

> You know, we categorise, we power play with labels. You know, a patient/ resident means you're sick. And I'm the nurse. And I'm in a position of power. It's all about power play, power dynamics, and as much as we try and teach, you know, person-centred or relationship-centred. It's a very, very, very difficult thing to deconstruct power hierarchies, labels and categories. (International Aged Care Executive 26)

Moreover, the document or form, with its labels and boxes, became the pernicious and obvious portrayal of the various legislation pillars in practice settings, hindering person-centred model implementation. The language used to categorise older people, especially in funding, was seen by interviewees as dehumanising and contributing to implementation challenges because it was focused on a deficit biomedical model. That is the way in which funding models and regulatory reviews often portray older adults, as inherently dependent or vulnerable, which becomes ingrained in institutional policy discourse. This was seen in how the interviewees referred to how older people, that they needed to be categorised and ultimately stereotyped to justify their funding classification and conform to requirements associated with the ACFI funding model (see also Chapter 3, section 5).

The antecedents to the *Aged Care Act 1997* (Cth) were the twin concerns of rising aged care demand and associated cost to the Federal Budget, as revealed in the inaugural intergenerational reports initiated by Federal Treasurer Peter Costello under the Howard Government in 1996. Rationing places became an important control mechanism (see Chapter 3) that was exacerbated by the online “My Aged Care” system, a key recommendation from the *Caring for Older Persons Report (Productivity Commission, 2011)*. The funding mechanisms associated with the reviews over the decade under consideration in this study, appeared to prioritise efficiency and funding compliance, as the funding calculations for the sector were reviewed (see Chapter 3, section 5).

Historically, regulations have been a point of friction between all the actors, being perceived as too onerous or, conversely, inadequate. The tensions and adversarial aspects of regulation were indeed brought up by the interviewees (Chapter 6). However, the power dynamics illustrated in the following quote highlights the experience of the explicit power associated with the regulatory processes from evidence provided to the Royal

Commission. Moreover, it demonstrates that both the regulatory framework and the posture of the assessors worked in opposition to the implementation of PCC models of care in practice.

> It has been my experience that the assessors have been adversarial during visits and are not willing to engage. This presents particular difficulties, as assessors will not have encountered this model of care before, having a collaborative process is critical to the assessors having an understanding of our operation. In my opinion, the ACQSC (and its predecessor the Aged Care Quality Agency), through its assessors, has shown resistance to the model of care. (Royal Commission Statement, 2019, p. 19)

Further to adversarial nature of power described above, the regulatory processes became more oppositional following the Oakden failure, the *Review of Quality Processes* in 2017 and ultimately the Royal Commission (see Chapters 3 and 5), with the dominant power dynamic focused more on the use of forms, and checking and actively seeking to fail providers:

> We had a very benign, too benign, system. Then we had Oakden, and we've now got an adversarial system. And with the pressure on things like the Royal Commission, and just this, the pendulum swings the other way, I think it would be some time before we get there. I think people have the right intent, but I think it is about catching people out a bit at the moment. (Australian Aged Care Executive, 40)

This study revealed that these power dynamics were a factor for all the interviewees, regardless of country and were consistent with several findings from the Royal Commission, specifically that the aged care system was too focused on legislative control (Royal Commission into Aged Care Quality and Safety, 2021, p. 74), with the above controls the antithesis of "choice" and the prevailing rhetoric. These dominant legislative pillars structures in aged care policy and legislative frameworks significantly influenced both the language and practices of care delivery. Moreover, they highlight that the prevailing attitudes have deep links to wider societal perspectives regarding older people, seeing them as a burden. This aligns with the socio-historical roots of Australian residential aged care, as outlined in Chapter 3, section 3.

> Anytime we categorise any group of people, then we identify them as "other". And as soon as you identify a group of people as "other" then they become "less than" and our challenge from a policy perspective in our country is it has been far too easy for

> policymakers to identify older adults as being "other" and "less than" and not contributing to society, and we have done a terrible job at identifying a role for, (for) older adults in our society and we've done ourselves a disservice. (Aged Care Executive 55)

These power dynamics reflect a binary opposition, between "the mission" of the provider versus "the business" of providing in a highly regulated sector such as residential aged care. When the policy shifts, legislative pillars and posture evoke implicit and explicit power that challenges person-centred model implementation. This leads to the second meta-inference, which follows.

7.3 "Box of Bias"–Language and Culture

The "box of bias" and its relationship to PCC model implementation was an unexpected finding, yet the sentiments expressed by the interviewees suggest a causal link through the power of the legislative and policy pillars, the bureaucratic requirements, and the terminology and language as they cascade through organisations to practice and practice culture. Terminology and language have the power to reinforce stereotypes and project social biases onto others (Applewhite, 2019; Aronson, 2019; Lakoff & Johnson, 2008). At the core of the challenge is that it is the implied meanings, rather than what is stated explicitly, that frame people's judgements about others (Brown, 2014; Gendron et al., 2015; Grey, 2021).

The first meta-inference "words make worlds" discussed above revealed a tension between the power dynamics of implementing person-centred models to enhance quality of care and quality of life of older people and the terms used in the shifting policy landscape. The requirement dictated by government agencies to complete forms and meet obligations for their various functions were deemed by the interviewees to create unintended consequences at practice levels, which resulted in a "box of bias". The perceived tension between the implementation of PCC models and the financial classification and risk management requirements or bureaucracy or "red tape"[6] were reported by the interviewees to work against the person-centred approaches being implemented. For example, the biomedical funding model unintentionally normalised

[6] 'Red tape': official rules and processes that seem unnecessary and delay results. (Cambridge English Dictionary, 2025)

terms such as "faller" instead of "a person who falls", "feeder" instead of "a person who requires assistance with the activity of eating", or "two-person assist" instead of "someone who requires the assistance of two people for activities of daily living". These terms can default to becoming casual and accepted jargon in practice, objectifying and dehumanising people and reflecting the bias that undermines an older person's dignity, identity and wellbeing (Durepos et al., 2022; Kitwood, 1997; Mintz, 1992; Sabat et al., 2011; Shem, 2010).

The normalisation of these "biases" is further perpetuated and extended when the regulator prioritises and requires risk assessments, and the associated risk mitigation plans have primacy over the older person's own choices. Collectively, these dehumanising terms become a categorisation or label of the older person that becomes casual and commonplace in practice settings, that is, a "box of bias". Further, they can lead to a transactional approach to care delivery and hence loss of respect for the person, who *becomes* the "label" or "bias" associated with the terms and language (Dowling, 2022; Grenier, 2007; Jilek, 2000; Shashkevich, 2019). Consequently, daily practices within residential aged care settings tend to replicate institutional logics that align with these discursive frames, stigmatising and marginalising people within care (Schoeneman, 2010).

> That's what they say, I'm a non-person. I'm a task. I'm a job. I'm number three on the worklist. Some residents will tell you that 'I'm just xxx….' (Australian Academic and Thought Leader 3)

Such associated terms become normative in culture, reflecting the dominant power of the regulatory pillar and working in opposition or hindering the implementation of person-centred models. This finding was common to all the countries represented in the interviews.

> And so, it is old, age-old truisms that if you don't respect your elders and you neglect them, then you will fail to learn the lessons from them and you will repeat the mistakes of their past. (International Aged Care Executive and Thought Leader 08)

These findings aligned with findings from the Royal Commission's *Neglect* Report, which highlighted a residential aged care culture that depersonalised older people and was deemed to be "neglect", the very opposite of "care".

> At the heart of these problems lies the fundamental fact that our aged care system essentially **depersonalises older people**. A routine thoughtless act- the cup of coffee placed too far from the hand of a person with limited movement so that they cannot drink it, the call buzzer from someone left unanswered, the meal left uneaten with no effort to help- when repeated day after day, become unkindness and often cruelty. This is how care becomes neglect. (Royal Commission into Aged Care Quality and Safety, 2019b, p. 6)

The impact of words is determined by the underlying message or intent, the individuals articulating them, and the prevailing political, social or emotional context in which they are expressed. Words extend beyond simple letter combinations forming sounds; they encompass symbolic meanings that influence people in various ways.

Political influence extends beyond mere rhetoric. Instead, for many of the interviewees, this language was antithetical to the practices of care and person-centred care implementation. The terminology imbued with political power shapes these policies and reviews, which drives behaviours and postures with references to "risk management" or "complex care needs". Consequently, it perpetuates constructs of people as passive recipients requiring oversight and control, thereby legitimising paternalistic approaches to care, which aligns with Kitwood's malignant social psychology (Kitwood, 1997, pp. 45-49).

What was also surprising was how these biases were deemed by the interviewees to reflect both implicit and explicit ageism. The meta-inferences associated with the legislative pillars and policy were perceived to perpetuate ageism and ageist attitudes. This was seen to be in direct conflict with what providers were seeking to implement through PCC models. The tension was palpable, as the following quote exemplifies:

> And one of the things that I think, and it's actually in the age care policy, and that's its ageist … I've sort of been thinking a lot about this. How do we, that is the system that we've created in Australia, reinforce ageism. (Australian Aged Care Executive 4)

This seemed so antithetical to the prevailing policy shifts and rhetoric of "consumer" and "choice", where paradoxically, the terms of "customer" and "consumer" were predicated on personal agency and market dynamics to support choice. Yet, how can the core tenets of choice and personal agency be realised when the lived experience is the antithesis of this policy intent? The antipathy to the terms "consumer" and "customer"

and the intent of a "market approach" to care which originated with both the *Aged Care Act 1997* (Cth) and accelerated by the *Aged Care Living Longer Living Better Act 2013* (Cth) and associated reforms (Tune, 2017) were discussed in Chapter 6. The ambivalence and antipathy expressed towards the terminology, reflects the comments by notable Australian author Thomas Kenneally:

> Words used in the new economics have a huge heft to them. When it comes to health, education, and welfare, we are no longer members of a human compact. We are no longer students, patients, battlers down on our luck. We are not members of a commonwealth anymore. We are clients of a system.
>
> The new nomenclature we've been subjected to alters our relationship to human services. Indeed, the trickle-down effect of the new economics was supposed by now to have replaced human services provided by government.
>
> But I resist the idea that all the world's a market, including health, in which our reality is to achieve the role of consumer, customer, client. For there is an obvious difference in human imagination and experience between a human undergoing cancer surgery and one buying an SUV. But not in the perception of market economics. (Kenneally, 2020)

These findings align with and extend the findings and commentary from the Royal Commissioners, exemplified by their challenge of the notions of "customer" and "market":

> The structure of the current system has framed around the idea of a "market" for aged care services where older people are described as "clients" or "customers" who are able to choose between competitively marketed services. (Royal Commission into Aged Care Quality and Safety, 2019b, p. 10)

Supporting this is the fact that many older people are in no position to negotiate prices, services or care standards meaningfully with aged care providers; indeed, many people require service provision in a time of crisis, such as a health-related event, when navigating the "market" becomes even more challenging and is confounded further when there is information asymmetry (Trigg, 2018).

> The notion that most care is "consumer-directed" is just not true. Despite appearances, despite rhetoric, there is little choice with aged care. It is a myth that aged care is an

> effective consumer-driven market. (Royal Commission into Aged Care Quality and Safety, 2019b, p. 10)

The findings of this meta-analysis provide unique insights into the role and influence of policy in residential aged care practice settings. Interestingly, while the Royal Commission considered the socio-historical, political, structural, cultural and system issues that impact quality of care and quality of life for older Australians, language was not considered a factor with regards to culture or how the terminology was translated to practice contexts. Yet, organisational researcher Chris Grey identifies “words” as a key aspect for consideration in organisational culture change programs. “No sensible person can say “well these are just words”. For we all know that words have the power to influence, to move, to inspire, to hurt and to repel people” (Grey, 2021, p. 15). The meta-inferences and findings of this study highlight the critical impact of language and terminology used throughout legislative and regulatory frameworks. These meta-inferences associated with power as described above, illustrate how terms and conditions can obstruct the implementation of the PCC model, creating a duality between the intended policy goals of choice, autonomy, agency and control, and their unintended consequences as they are translated through to practice contexts.

7.4 Evaluation of Existing Theories and Models

7.4.1 Findings as They Related to the Literature and Models for PCC Implementation.

The models available to support implementation (Chapter 2), particularly those under the AgingIn™ banner, posit various elements, such as environmental aspects, and small clustered, homelike settings to provide choice and deinstitutionalise practice. While the Australian-authored studies (Cleland et al., 2021; Dyer et al., 2019; Naidu, 2019; Petriwskyj et al., 2016a; Petriwskyj et al., 2016b) in the literature review (Chapter 2) used the terms “customer” and “consumer” and referred to shifting policy, notably, there was no consideration in any of the studies of the wider legislation as conditions as a factor impeding the implementation of PCC models. Although (Shier et al., 2014) considered policy more broadly as an input in the evaluation framework postulated, other studies focused on the limited quality-of-life and quality-of-care outcomes, making no mention of the policy or legislation that may have been impeding the wider results and successes of implementing PCC models. Most interestingly, wider policy and legislative pillars

were not mentioned in any of the 13 major studies published between 2010 and 2023, despite the fact that they accounted for more than 200 papers considering the policy context as it related to practice. Further, none of the studies considered the language, the posture of the regulator or funding instruments as factors that could impact PCC model implementation (Braithwaite et al., 1994). Moreover, they were silent regarding the potential for unintended consequences of the legislation governing aged care.

What this study has underscored is that providers want to deliver person-centred/relationship-centred approaches to improve quality of life and quality of care in alignment with their mission and organisation intent. It has challenged the notion that providers are limited in their ability to implement PCC models in practice. Conversely, it has demonstrated that providers appear to know what and how to implement PCC models. What it also does is extend the recommendations of Caspar et al. (2016) where they allude to policy as an aspect to consider with regards to reinforcing and supporting implementation.

This study is believed to present novel findings regarding perspectives on the changing terminology used to refer to people in residential aged care and the implementation of person-centred models. No studies in the reviewed literature have considered shifting policy in this regard. As mentioned in Chapter 2, Chapin's (2010) study, was the only study that referred to "customer" prior to the Australian-authored studies from 2015 in the literature review. The term "consumer" was seen to be enforced from policy and, with the exception of one UK provider interviewed, wholly disliked and antithetical to practice settings (see Chapter 6 section 5.1).

The findings also reflect terminology pluralism and fatigue, with person-centred care seen less as a model and more as a philosophy (Dyer et al., 2019), and others preferring such umbrella terms as "relationship-based care" which further conflates what is happening in practice settings and in policy. The next section will review these findings through a Bourdieusian analytical frame.

7.5 Analysis in Relation to Bourdieu's Theories

Having moved abductively with both the empirical data and my practical experience, I now examine the theoretical framework employed for this final part of the study through

a Bourdieusian lens. The meta-inferences of language and power and language and culture found in this study align with many of Bourdieu's "thinking tools" or framework to understand social spaces. Other theorists, such as Goffman (Goffman, 1968, 2009, 2014, 2017; Kleinman & Hall-Clifford, 2009) could have been used in relation to stigma, spoiled identity and asylums. Alternatively, Foucault could have been used in relation to language and bureaucratic power (Foucault, 1971; Kelly, 2010; Taylor, 2014), which has been used as an analytical frame for related studies regarding frailty and ageing (Grenier, 2007; Grenier & Hanley, 2007; Hyde et al., 2014). The same applies to the American theorist, Estes, with regards to their work regarding the interrelationship of the political economy, power and ageing (Estes & Phillipson, 2002). Similarly, and finally, feminist theorists such as de Beauvoir (De Beauvoir, 1996, 2007) or the contemporary Folbre sought to explain how gender shapes the experiences of ageing and the provision of care and support (Folbre et al., 2013).

7.5.1 Rationale for Bourdieu as a Theoretical Framework

Bourdieu's framework was selected for this study because of its focus on the social space where language is valued and exchanged (Bourdieu, 1991), which built on the work of his colleague and contemporary Jacques Derrida (Derrida, 1976; Sabat et al., 2011). The components of Bourdieu's framework are considered crucial as it offers a way to analyse the relationship between language, power and social structures, as revealed in the findings. Further, a diachronic approach to language reveals how power dynamics and historical contexts shape language in practice. Before proceeding with the wider discussion based on these meta-inferences, there follows a brief overview of Bourdieu, his sociological approaches and theories, the rationale and the applicability of these to the meta-inferences and wider findings of this study.

A Bourdieusian framework had several advantages considering the meta-inferences. Bourdieu aimed to uncover the hidden structures of social worlds and the mechanisms behind their reproduction and transformation (Grenfell, 2012). For Bourdieu, research in the social world was essentially empirical, an empiricism seen as structured, relational and dynamic in nature. His work was primarily concerned with the dynamics of power in society, especially the diverse and subtle ways in which power is transferred and social order maintained within and across generations. For Bourdieu, language was central to

these relationships and was deemed to be associated with a complex set of social, historical, and political conditions of formation. A brief background to Bourdieu and how these influences were formative for his philosophical approach follows.

7.5.2 Background to Bourdieu

Pierre Bourdieu is regarded as one of the foremost social philosophers of the 20th century. His output included extensive studies of education, culture, art, sport and language (Burawoy, 2019). He went beyond being a sociologist to being regarded in the same "public intellectual" role as Sartre, de Beauvoir and Foucault. Issues surrounding language permeate Bourdieu's entire oeuvre (Grenfell, 2022).

Bourdieu was impacted by three major life experiences, his upbringing in rural France, his time in Algeria and his return to rural France. It is from these primary and foundational experiences of real life – the intensity of engagement – that Bourdieu's concepts of *Field, Habitus and Capital,* emerged which collectively became *Outline of Practice* (Bourdieu, 1977; Grenfell, 2014). He returned and re-returned to these on a regular basis and gathering new insights with a new gaze or a metanoia, (Grenfell, 2022, p10). Bourdieu drew not only from these experiences but also from his original studies in philosophy and his move to sociology after his time in Algeria. He also used anthropology; Grenfell describes Bourdieu's approach as a sociological philosophy (Grenfell, 2022).

7.5.3 Bourdieu's Concepts of Field and Power

Bourdieu's notable thinking tools of "field", "capital" and "habitus" (sometimes referred to as the trinity of thinking tools) are central to his major life work *A Theory of Practice* (Bourdieu, 1977; Grenfell, ND) and he developed them into a formula to show their interdependence, thus: [(Habitus) (Capital)] + Field = Practice (Maton, 2014, p. 50). Following the approach suggested by Grenfell to ensure clarity with these Bourdieusian tools, these terms are italicised in this dissertation "to remind us that such words are more than straight descriptors but imply an entire 'theory of practice' and epistemological perspective. Without this reminder, they easily become mere metaphors, heuristics, etc." (Grenfell, 2022, p. 10). Bourdieu's concepts that follow are depicted in **Figure 29**, adapted from an online Bourdieu video tutorial (Reynolds, 2013).

A *field* is a structured space of positions held by agents or institutions, in which the positions and their interrelations are determined by the distribution of different kinds of resources or *capital* (Bourdieu, 1991). Bourdieu regarded *fields* as a site of struggle where power relations are constantly negotiated, contested and reinforced (Bourdieu 1993, p.73.) Each *field* has its own logic and rules of functioning, which participants internalise to varying degrees (Grenfell, ND).

> All participants must believe in the game they are playing and in the value of what is it stake in the struggles they are waging. The very existence and persistence of the game or field presupposes a total and unconditional "investment" a practical and unquestioning belief, in the game and its stakes. (Bourdieu, 1991, p. 15)

Within any *field* of study– education (Bourdieu, 1988), arts (Jenkins, 2002) groups struggle for dominance over their field to acquire forms of *capital* that are valued in the *field* (Collyer et al., 2015; Travaglia & Braithwaite, 2009). These *fields* and their tensions are associated with their socio-historical origins (Grenfell, 2022). These *fields* of practice are also constituted by, or as a result of, the conflict that is involved when groups or individuals attempt to determine what constitutes *capital* within a *field,* and how that *capital* is to be distributed. "Cultural *fields* … are made up not simply of institutions and rules, but of the interactions between institutions, rules and practices" (Webb et al., 2002, pp. 21-22). *Fields* interact with each other and are hierarchical; most are subordinate to the larger field of power and class relations (Bourdieu, 1991) as per this quote from Jenkins:

> A field, therefore, is a structured system of social positions— occupied either by individuals or institutions— the nature of which defines the situation for their occupants. It is also a system of forces which exist between these positions; a field is structured internally in terms of power relations. Positions stand in relationships of domination, subordination or equivalence (homology) to each other by virtue of the access they afford to the goods or resources (capital) which are at stake in the field. (Jenkins, 1992, p. 53)

The orange circles in **Figure 29** demonstrate that there are a number (not exhaustive) of *fields* for "residential aged care", "society", "government", "provider", "lobby groups" and "older person" that relate to the practice context (Collyer et al., 2015) and they are all struggling for *capital*. For Bourdieu, *fields* operate with both the accumulation and processes associated with *capital*, (Thomson, 2012, p. 67) which is more than the

economics, although the logics of the *field* where production and exchange take place produce unequal relations (Collyer et al., 2015). While *capital* can be social or cultural and be readily exchanged, it is also about power and this struggle for power is significant leading him to term these as *symbolic power and violence* (Burawoy, 2019; Webb et al., 2002).

The last aspect in Bourdieu's trinity of thinking tools, *habitus* is a person's embodied history, in other words, the sum total of what they have been taught to believe about themselves, their class, culture and history. *Habitus* focuses on our ways of acting, feeling, thinking and being. It captures how we carry within us our history, how we bring this history into our present circumstances and how we then make choices to act in certain ways (Grenfell, 2014, p. 51).

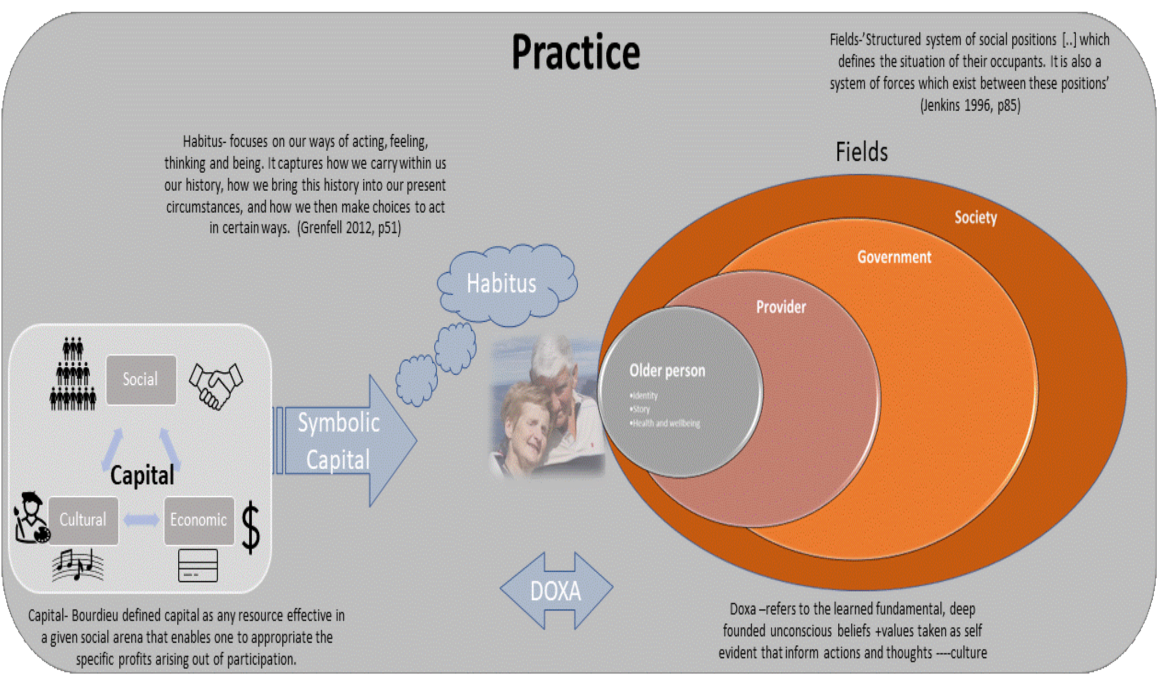

Figure 30 Bourdieu’s Theory of Practice, Adapted from Reynolds (2013)

Doxa refers to the learned, fundamental, deep-founded, unconscious beliefs and values, taken as self-evident universals, that inform an agent’s actions and thoughts within a particular field. *Doxa* tends to favour the particular social arrangement of the *field*, thus privileging the dominant and taking their position of dominance as self-evident and universally favourable (Bourdieu, 1991).

Symbolic power is the imposition of schemes of perception and thought that appear neutral and natural but reflects and reinforces the power relations within a *field*. This process, Bourdieu argues, is often misrecognised by those subjected to it, leading to a tacit acceptance of social hierarchies because the power dynamic is seen as legitimate, as reflected in the following quote:

> For symbolic power is that invisible power which can be exercised only with the complicity of those who do not to know that they are subject to it or even that they themselves exercise it. (Bourdieu, 1991, p. 164)

Bourdieu further states that power constructs social reality by use of symbols and language and those who use or enforce these words; this gives meaning to the social world, “symbolic power”.

> Symbolic power–as a power of constituting the given through utterances, of making people see and believe, of confirming or transforming the vision of the world and, thereby, action on the world and thus the world itself, an almost magical power which enables one to obtain the equivalent of what is obtained through force (whether physical or economic), by virtue of the specific effect of mobilization is a power that can be exercised only if it is recognised (reconnu), that is, misrecognised (méconnu) as arbitrary [...] What creates the power of words and slogans, a power capable of maintaining or subverting the social order, is the belief in the legitimacy of words and of those who utter them. And words alone cannot create this belief. (Bourdieu 1991, p. 170)

Finally, *symbolic violence*, another key concept in Bourdieu's work, relates to the application of terms or processes that appear neutral and natural, but reflect and reinforce the power relations within a *field,* for example "people being denied resources, treated as inferior or being reduced in terms of realistic aspirations" (Webb et al., 2002, p. xvi). This process is often misrecognised by those subjected to it, leading to a tacit acceptance of social hierarchies (Schubert, 2014).

As will become evident, Bourdieu posits that categorisations shape and organise the world, thereby structuring individuals within it (Bourdieu, 1997; Watkin, 2022). With this contextual overview and rationale regarding Bourdieu's theories, I now apply Bourdieu's thinking tools to the meta-inferences and findings that are associated this study.

7.5.4 Bourdieu as an Explanatory Framework for the Study Findings

This study has highlighted that in the implementation of PCC models of care, there appears to be a tension arising from policy and legislative frameworks that hinders implementation. These intersecting political, historical, economic and socio-cultural dimensions are conceptualised as entering one's inner world and following from Bourdieu these external aspects can influence a care staff's thoughts and actions, which impact practice contexts. These spheres are neither exhaustive (one could add layers or divide them into further layers such as legal or media); nor can they be separated from each other; each layer is interdependent and in tension with the other layers.

Figure 30 depicts the interaction between these two meta-inferences to show how language and terminology can affect PCC implementation. In this figure, the first circle represents the intent by a provider organisation to implement PCC models in their

services. In the implementation they encounter the political and legitimate power associated with the legislative pillars, policy terminology and their associated power dynamics; that is, "words make worlds". These create the *symbolic power* and control with regards to aged care delivery, through the legitimacy and credibility of the regulatory processes, the funding formulas and allocation, the regulatory requirements, the penalties for non-compliance or breeches, and the obligations associated with being an "approved provider". These approved provider requirements consequently influence and impact on practice settings, resulting in the "box of bias", that is, the unintended consequences associated with terminology and language, the associated dehumanising practices and bias perpetuating *symbolic violence* that hinders or obstructs the implementation of PCC models in practice contexts. These dynamics result in ongoing tension between the actual quality of care provided through the implementation of PCC models and the evaluation and funding of such care within regulatory or legislative frameworks and their associated power.

These findings align with definitions of Bourdieu's *field*, where Webb et al. (2002) suggest that:

> people's practices are shaped by the "field/s" within which they operate, with each field comprising a combination of: discourses, institutions, values, rules and regulations – which produce and transform attitudes and practices [as well as] rituals, conventions, categories, designations, appointments and titles which constitute an objective hierarchy and which produce and authorise certain discourses and activities (Webb et al., 2002, p. 33).

For Bourdieu, the social space is where language is valued and exchanged, influencing how individuals use language in different contexts. This concept is crucial, as it provides a lens through which to analyse the relationship between language, power, and social structures. In this way, policy hegemony not only scripts how aged care is conceptualised but also shapes the social realities of care work, reinforcing *symbolic power* relations that become internalised by both staff and residents through processes of *symbolic violence* (Bourdieu, 1991; Eyers et al., 2024). Whoever has the legitimacy imposes the rules and has the power (Kramsch, 2020). In this study and through the analysis of the regulatory reviews, lobby groups or peak providers, government agencies, large provider bodies,

unions and others were all involved in progressing and designing the move to "consumer-directed care".

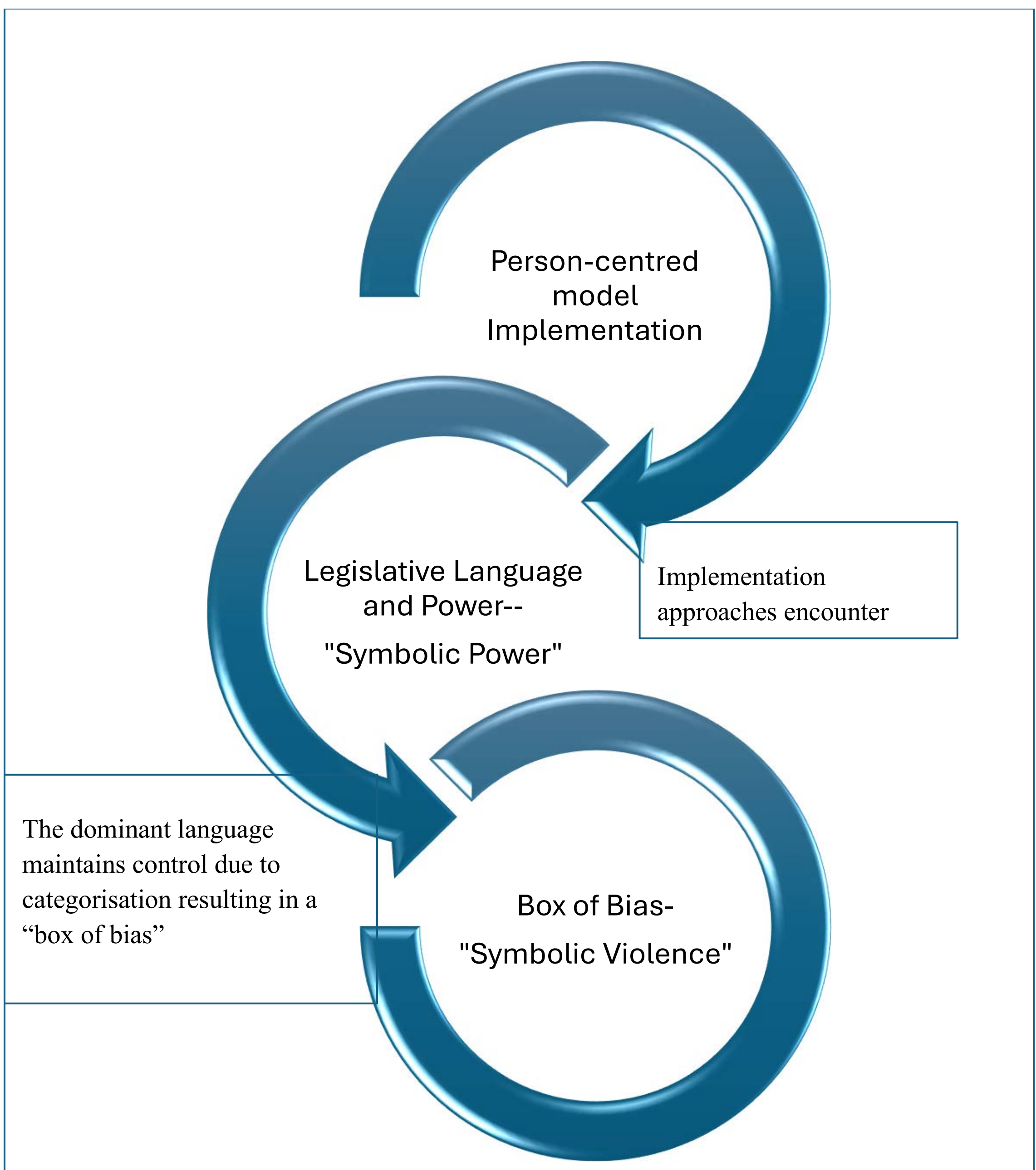

Figure 31 Application of Bourdieu Theory to PCC Model Implementation

Bourdieu regarded language as more than communication; it was also a mechanism of power and domination, coming from the institutional conditions which surround words and in which they are located (Bourdieu, 1991; Grenfell, 2014; Kramsch, 2010; Lakoff

& Johnson, 2008). Bourdieu argues that language only has meaning in terms of the situations within which it is immersed at any one time and place – literally, a game! For him, the schemes of perception (which individuals hold) and the language (which carries the perceptions) are each homologously linked to social structures, which act as both their provenance and social destiny (Grenfell, 2022; Jenkins, 1992). Just as social agents exist in network relations, so do words exist in networks of semantic relations to each other. Further, they partly acquire their meaning in terms of difference and similarity with respect to each other instantiated at specific times and places. Sense and meaning, then, are always determined in the interplay between individual meaning and the social context in which language is being expressed. Words form a part of such social space and fields and are ultimately used to represent a particular way of thinking (Grenfell, ND).

What this study has ultimately revealed is a fundamental dualism in Australian aged care policy: on one side, the promotion of "person-centred" or "consumer-centred care" and on the other, an overwhelming focus, evident across the first three reviews and inquiries in particular, on the fiscal considerations associated with aged care (Productivity Commission, 2011; Tune, 2016, 2017). This financial preoccupation manifested in multiple ways: funding constraints, data collection and reporting requirements, quality metrics and measurements, and stringent approval processes for care delivery (Duckett & Stobart, 2021; Duckett et al., 2020). The interplay between these competing priorities, that is, the aspiration for individualised, high-quality care versus the practical realities of cost management, created a profound tension that potentially impacted the dynamics associated with implementing person-centred care models in the Australian aged care system. These dualisms were noted by Peter Gray, S.C., assisting the Royal Commission, in his closing statements, when he shared the Cabinet-in-Confidence memorandum regarding the *Aged Care Act 1997* (Cth) highlighting funding constraints, quotas and classification restraints in terms of numbers and funding. The exhibit ended with the words, "… and so total control of its theoretical cost" (Closing Statement, 2020).

These findings underscore that policy language needs to be cascaded with due consideration because words represent who we are and how we think. This leads to another consequence associated with these findings: from the explicit power dynamics associated with policy, there could appear to be a link between the language of policy as a driver for the "box of bias" and how and why these terms and context in which they are

used have become normative (Bourdieu, 1991; Kramsch, 2020). Abductively, these findings and inferences appear to hinder PCC model implementation, creating a tension between autonomy and choice versus risk management and paternalism (Duckett et al., 2020).

Language and terms also appear to perpetuate the prejudice, stigma and ageism that is all too often reflective in society (Duckett et al., 2020; Nelson et al., 2002). On this point of ageism, the last word goes to one of the interviewees:

> Well, you touched on the perfect irony that is ageism and where it's the only form of prejudice, we are actually prejudiced against your future self. (Australian Aged Care Executive 29)

These findings informed by Bourdieu's thinking tools also align with the RCACQ&S findings, which highlighted that what happens in residential aged care is reflective of paternalism towards older people and ageist attitudes in Australian society:

> As a nation, Australia has drifted into an ageist mindset that undervalues older people and limits their possibilities, Sadly, this failure to properly value and engage with older people as equal partners in our future has extended to our apparent indifference to aged care services. Left out of sight and out of mind, these important services are floundering. All too often, they are unsafe and seemingly uncaring. (Royal Commission into Aged Care Quality and Safety, 2019b, p. 1).

These findings are also consistent with those of the Francis Report into the Mid-Staffordshire Foundation Trust (Francis, 2013) and Carboni's factors of homelessness (Carboni, 1990), resulting in the fabric of disregard and non-personhood, disconnectedness, powerlessness/dependence, insecurity/ uncertainty, and a fundamental loss of the human right to dignity.

7.5.5 Summary

Through an abductive approach, this study has demonstrated that for person-centred care models to be fully realised, an underlying hegemony must be considered as a key aspect in the implementation of PCC models for practitioners. Why? Because language and

words are ubiquitous. We think words, hear words, speak words, sing words, write words, and read words, respond and imbibe the intention associated with words, each and every day. We see and hear these words *(doxa)* everywhere and every day associated with residential aged care, but how are these words interpreted and how do they impact practice for the older person who is living in a care home or residential age care facility? Surprisingly, in almost every way, this is because words are in everything from the legislative documents that underpin policy and reform documents, through organisational mission and vision statements, through to values and policies at the organisational level.

7.6 Significance of the Study

The study is important for several reasons. Firstly, it examined Australian Government legislated reviews documents and the associated language on the implementation of person- centred care models in residential aged care practice contexts; this, to the best of my knowledge, is unique.

Secondly, another key strength of the present study was the study’s design—mixed methods with data triangulation—enabled each method to use its own measurements, then compare and contrast them. The combination of quantitative with Leximancer and qualitative data and analyses enabled a holistic presentation of the insights and perspectives relating to the influence of policy as person-centred models are being implemented is a new approach. Related to this point, the use of mixed methods to understand the implementation of person-centred care models in a dynamic policy context, with both a pandemic and a Royal Commission of Inquiry happening in tandem, resulted in more evidence and stories like Merle Mitchell’s becoming mainstream and highlighting the policy disconnect.

A further methodological strength of the study was the number of interviews (46), the representation of aged care executives, person-centred model designers and facilitators, and the number of aged care researchers and academics. Additional strength derived from the number of countries represented, that is, five, namely, Australia, Canada, the USA, the UK and South Africa). This representation is believed to be considerable and adds to the depth associated with the findings and the relevance of the study to other countries.

The Australian aged care system is at a significant inflection point. This was highlighted in section 3 with regards to the new *Aged Care Act 2024* (Cth), effective November 1, 2025, a key recommendation from the Royal Commission, and predicated on human rights. These results were timely, as the new Act comes into effect on 1 November 2025, replacing the existing *Aged Care Act 1997* (Cth). It addresses 60 recommendations from the Royal Commission and reflects considerable co-design and consultation with older people, providers and peak bodies. Interestingly, the prevailing term with which it refers to older Australians is “participants”. How this new term is defined and the constituent aspects of this term and PCC models were still under development at the time of writing. Central to the Act and the sweeping reform agenda in the wake of the Royal Commission have been statements about what underpins and constitutes quality care in the sector. For example, it states:

> High quality aged care puts older people first. It assists older people to live a self-determined and meaningful life through expert clinical and personal care services and other support, provided in a safe and caring environment. High quality aged care is respectful, timely and responsive to older people’s preferences and needs and assists them to live a dignified life. High quality aged care is provided by caring and compassionate people who are educated and skilled in the care they provide. It enables older people to maintain their capacities for as long as possible, while supporting them when they experience functional decline or need end-of-life care. High-quality aged care delivers a high quality of life. It enables people to engage in meaningful activities that provide purpose and provides the opportunity for people to remain connected to their community. (Royal Commission into Aged Care Quality and Safety, 2021, p. 91)

The new Act will be subject to a legislative review to assess its impact. This study’s finding would support that any recommendations and changes from future legislative reviews be considered and reviewed for any unintended consequences as they relate to practice contexts. In the words of an international aged care executive:

> If you get your language right, it draws you into the future. If you get your language wrong, you fight the future. (International Aged Care Executive 38)

The findings from this study regarding terminology extend the initial work of O’Dwyer (2013), whose examination of terminology in the Irish regulatory framework found that PCC in the regulatory framework was synonymous with neoliberalism (O’Dwyer, 2013).

this study also extends the implications of neo-liberalistic approaches and their challenges in practice as described by Brennan et al. (2012) and Fine and Davidson (2018). While the Australian policy and legislative frameworks ostensibly offer choice, they continue to emphasise control through the language, posture and tone associated with governmental, departmental and regulatory authority (Petriwskyj, Gibson, et al., 2015a). The factors that pertain to this meta-inference and the timing of this study were the protective mechanisms providers were experiencing because of the COVID-19 pandemic. Public health orders were focused on residential care services (Bunting, 2020). These orders were felt acutely due to several COVID-19 breakouts resulting in deaths which in turn resulted in enhanced monitoring and sanctions for providers (Ibrahim, 2020; Royal Commission into Aged Care Quality and Safety, 2020). Further, the Australian media and Royal Commission had criticised the regulatory processes for being too weak after the Oakden scandal and other failings associated with quality (Chapter 3). The regulatory pendulum became (and was experienced as being) very adversarial.

This study establishes that in the implementation of PCC models, the policy context and the language contained in documents need to be considered and translated into practice settings. This study extends insights derived from strategic considerations associated with implementing PCC models (McCormack et al., 2024). Implementing person-centred models of care is a continuous process; therefore, any changes to the terminology and posture of the regulatory agency and financial instruments need to be considered. This translation requires that any new policy is considered in terms of both the external policy context and the internal context, that is, the organisational strategy and strategic initiatives of each provider. These then need to be articulated and disseminated within the organisation, through every level and to the practice context to include awareness, discussion and understanding.

This study's contribution to the vast literature on person-centred models and culture change implementation demonstrates the value of mixed methods approaches to research and analysis. Further, the study contributes new evidence about implementing person-centred care models, and the need for strategic alignment of the organisation's mission and vision with its practice settings. This need for alignment across all executive portfolios has been a central finding of this study, particularly with regards to regulatory compliance, governance and funding as they relate to model implementation.

In terms of the transferability of the inferences, the study's explanatory sequential mixed-methods design, using policy documents and interviews, is applicable across, first, health and social services and then across all aspects of government policy, education, climate, finance and other portfolios. The methodology can be used in other industries and organisations where large reviews and/or policy underpin service delivery, for example, higher education, airlines and hotels.

7.6.1 Chapter Conclusion

This chapter has synthesised the three key findings of this thesis and offered an interpretation of these findings using a Bourdieusian framework. In so doing, the thesis offers a new consideration in the implementation of person-centred models of care and the language used within dynamic policy environments. It has demonstrated how the study has answered the research questions to support and add to the empirical literature on person-centred models and their implementation.

In the next, and final chapter, I give the implications, limitations and suggestions for future research that have arisen from this research.

8. CONCLUSION

8.1 Introduction

We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time.

(Little Gidding, TS Elliott 1943)

This final chapter discusses the implications for person-centred care model implementation through policy and practice; it then describes some limitations of the study, proposes potential areas for further research and concludes with some personal reflexivity associated with the study's findings.

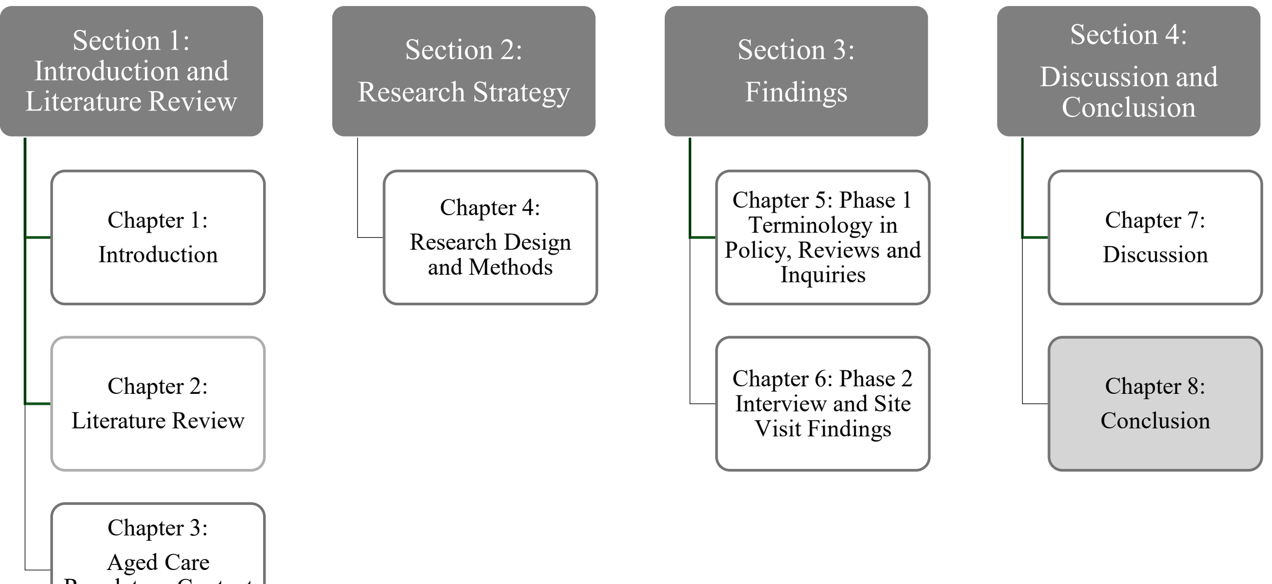

Figure 32 Thesis Outline Chapter 8

Through an explanatory sequential mixed-methods design, the study aimed to understand how the language and terminology used in government policy influence the implementation of person-centred care models in residential aged care in Australia. The research questions and findings (short form) related to this study are presented in **Table** 39.

8.2 Summation, Answers to the Study Aims and Questions

Table 39 Study Aim and Research Questions

Study Aim	Research Questions	Concise Answer	Corresponding Thesis Chapter
To examine how the language and terminology used in government policy influence the implementation of person-centred care models in residential aged care.	What are the key language and terminology shifts in aged care reviews 2011-2021?	Policy documents revealed a shift from care recipient to consumer-directed care. While these shifts were apparent the Leximancer analysis revealed a focus on the legislative pillars of care – i.e. regulation, funding, approval and governmentality.	Chapter 3
	How do aged care leaders perceive the relationship between legislative and policy terminology and the implementation of person-centred care models in residential care?	The interviewees reported that while they understood the need for the associated legislative pillars of care – i.e. regulation, funding, approval, the manner in which these were conducted and/or implemented, and the associated control, hindered the implementation of person-centred models.	Chapters 5 and 7
	What are the perspectives of aged care leaders with regards to implementing person-centred models in residential aged care?	The interviewees were all motivated to deliver quality care and enhanced quality of life but felt the tensions of the legislative pillars and the posture of the regulator as they sought to implement and deliver PCC models in practice contexts.	Chapters 6 and 7
	How can international perspectives inform our understanding of implementing person-centred models of care and compare them to the Australian context?	Similar findings regarding the posture of the regulator and the deficit funding models in Australia, frustrating PCC model implementation.	Chapter 6

These findings illustrate the importance of understanding the legislative pillars as they relate to the implementation of person-centred models in residential aged care settings. The implications of these findings are presented below.

8.3 Implications of this Study for Practice and PCC Implementation

This study established the interrelationship between policy and practice. It demonstrated how language drives mindsets and behaviours throughout the aged care system. Therefore, implementing person-centred models requires a deep appreciation of the wider dynamic policy context as it relates to practice. This is perhaps more profound than previously appreciated. Consequently, for a PCC model to be implemented successfully, there are some important implications to consider at provider and practice levels as well as at government policy levels, bearing in mind the aforementioned interdependency.

8.3.1 Implications for Policy and Practice

This study suggests there is a link between policy and practice; therefore, it is essential that the terms in policy drive practices that allow people to feel honoured and respected. Aged- care service delivery is very different to hospital care, where lengths of stay can be shorter and by nature are transitory. Conversely, in residential aged care, people actually live in these services, and can do so for considerable lengths of time, to the extent that ultimately these services are their homes. So how can they, as residents living in these homes, continue to contribute the essence of quality of life and person-centred care models to what is their own home. This was highlighted by Merle's evidence, as the voice of the older person, at the outset of this study and how older people/ residents are honoured in this process. Indeed, the voice of older people needs to be amplified in policy formulation.

This study has highlighted the definitions and components of PCC and the terms used to refer to people and how they relate to quality require further elaboration, explanation and indeed discussion across aged care, building on the research of the Royal Commission (Cleland et al., 2021). These findings underscore the systematic review findings of Costa et al. (2019), where terms, labels and their relationship to quality should be explored and negotiated as policy is being prepared (Costa et al., 2019, p. 14).

This study has also highlighted that these definitions need to embody the constituent aspects of person-centred care. As they relate to quality care provision, they need to be explained thoroughly in all key policy or review documents, not just in a table of abbreviations. For example, Commissioner Briggs captured the essence of PCC in this paragraph from the final report:

> Care should begin with an understanding of the experience through the eyes of each older person. Every person’s story is different. Some people will arrive at the aged care system following a different transition, such as ailing health or the loss of a partner, while others arrive with different histories, jobs, beliefs and traditions, and some will carry the burden of life’s trauma. Understanding and respecting the unique life experiences of people accessing care is affirming. The message it sends us - you are seen, heard and you matter. Everyone has their own needs, preferences values, feelings and expectations. These should be at the person’s experience of care. (Royal Commission Final Report 2021, p 31)

Ideally, these terms should be co-designed and considered from all perspectives, not just with peak bodies, or lobby groups, but with genuine engagement and co-design, to ensure they are not taken out of context. Groups such as Think Local Act Personal in the UK provide some useful guidance with regards to this point. As an agency, “they work to make care and support more personalised, so that people have the choice and control they need to live life their way” (http://thinklocalactpersonal.org.uk)[7]. This includes local provider policy and macro-level government acts or legislative underpinnings to support person-centred model and policy development.

Furthermore, what constitutes quality care in aged care settings was thoroughly examined through round tables and commissioned studies during the Royal Commission. As the new Act is implemented, it aims to shape future practice settings around human rights and incorporate recommendations on the design of small houses as a key component. It is important to understand how older individuals perceive quality of life and quality of care and the language of care settings that supports human rights through a co-designed,

[7] TLAP Home – http://thinklocalactpersonal.org.uk

interdisciplinary approach. This should be translated into model design with a comprehensive evaluation framework and action research.

The models and approaches that support PCC are essentially silent on government and policy context as they relate to the process of implementation and they could benefit from including practical pointers to interpret, align with or support policy during their implementation.

8.3.2 Implications for Person-Centred Model Implementation and External Agencies

This study has demonstrated that the regulatory agencies are key stakeholders when implementing person-centred models of care. A number of implications for consideration regarding key personnel (executive level team members) and their interactions with regulatory agencies arose from this study and from evidence to the Royal Commission. These implications are:

- Key personnel need to take the time to consider and demonstrate how the model of care being implemented aligns with regulatory requirements.
- These key executives should then consider how they inform, educate and demonstrate how the person-centred model aligns with the regulatory processes and how it is expressed within the organisation.
- The person-centred model implementation further requires that managers and care staff can demonstrate this alignment to the regulatory assessors (this aligns with my own practical experience).
- In the Australian aged care context, this understanding also applies to board members who have governance and legislative requirements regarding care delivery and compliance. Board members should understand the model of care in practice, and how the model is influenced by decisions at taken at an organisational governance level too.

8.3.3 Implications for Person-Centred Model Development

There appears to be a place for immersive programs and reflexivity as part of PCC model implementation to help all team members understand the unintended consequences of policy language in practice contexts. Some notable models and approaches that could be

extended are “My Home Life” (Eyers et al, 2006, Owen & Meyer, 2012) and practice development schools (McCance & McCormack, 2017). One immersive model known to this researcher was developed by Hannan at Action Pact as part of their PersonFirst® (https://www.actionpact.com/about/personfirst) train-the-trainer program based on Kitwood’s research (Hannan, 2018). In this immersive program with frontline teams, staff learn techniques regarding how language and actions can be associated with Kitwood’s core aspects of malignant social psychology, e.g. disempowerment, infantilisation, labelling, stigmatisation, objectification, outpacing people in care and /or older people, (Kitwood, 1997, pp. 46-47). However, no formal evaluation of the PersonFirst® program has been conducted, though Hannan states that anecdotal feedback from frontline teams reflect similar outcomes associated with a study by Ballard et al. (Ballard et al., 2018; Hannan, 2018). Using a research partnership to conduct an empirical evaluation could further demonstrate benefits in showing how practice contexts and cultures are reinforced by language and policy. These approaches could be used for all stakeholders in aged care.

8.3.4 Implications for Person-Centred Model Implementation and Design

The ACRCQ&S made a recommendation regarding facility design and a move to small house models with dementia design principles, Recommendation 105-107. The resulting *National Aged Care Design Principles and Guidelines* (Seemann, N. et al 2024) to support these recommendations are welcome. Sadly, though the document is silent on essential aspect of PCC and PCC model implementation and practice change. The findings from this study and other implications outlined here are important considerations to realise the full extent of what these important guidelines can offer to Older Australians regarding quality of life and quality of care.

8.3.5 Implications for Person-Centred Model Implementation and Technology

The red tape and box-ticking associated with forms and assessments that were perceived as additional burdens could be ameliorated with greater uptake and interoperability of technology platforms in the aged care sector. Completing core information once and having this information transfer across all the required forms could release time back to frontline staff to spend with older people.

8.4 Limitations of the Study

Some limitations must be considered when interpreting the findings of this study. Conducted as it was during the COVID-19 pandemic, public health orders prevented the researcher visiting sites to the extent that was initially hoped. The site visits would have added richness to the initial argument with regards to how language shapes culture in the practice context. The study was conducted during a time of high volatility and uncertainty in the field because of the *Royal Commission into Quality and Safety in Aged Care.* Media scrutiny of the aged care sector remained high due to both the pandemic and the resident and family experiences associated with practice failings and what became the interim report *Neglect*. (Royal Commission into Aged Care Quality and Safety, 2019b).

Conversely, the Royal Commission had many benefits in terms of the release of information. Federal Cabinet minutes associated with the implementation of the *Aged Care Act, 1997* were released for the first time and made possible due to the broad remit and forensic nature of the Commissions Act. The Commonwealth Department of Health and the Australian Aged Care Regulator were under significant scrutiny due to the widespread failure highlighted by the Oakden scandal (chapters 3 and 6). Consequently, these agencies were perceived to be more adversarial, in their approaches towards the sector, as outlined in Chapter 7. This could have been a result of the increased scrutiny from both the Royal Commission and the media, which cascaded to the providers and influenced their responses.

Finally, the research included only English-speaking countries. For instance, while I did not elicit ethnic or data, I believe that no Aboriginal and Torres Strait Islander peoples were represented in the interviewees. Further, only English publications were referenced in literature reviews, hence, relevant research in other languages was not included.

8.5 Suggestions for Future Study

This study interviewed a diverse group of national and international providers, aged care researchers and developers of person-centred models. Future studies aiming to gain a comprehensive understanding of how policy language translates into practice should consider interviewing older individuals residing in residential aged care services and their

families. Gathering their perspectives on their experiences could provide valuable insights for researchers seeking to understand the implications of language and practice.

This study has demonstrated the effectiveness of using government policy reviews and Royal Commission reports to understand policy dynamics as they relate to practice. Similar to (O'Dwyer, 2013) approach, there is use in reviewing funding documents and regulatory standards with content analytical approaches and tools such as Leximancer to ascertain language and semantic meanings as they relate to practice under the auspices of the new Aged Care Act here in Australia, or in other regulated industries in other countries.

This study has highlighted a link between policy and practice particularly the influence of funding aspects on care delivery and PCC model implementation; future studies could benefit from the inclusion of health economists and legal experts as an added lens to the implications for practice to extend these findings.

The demographics presented in Chapter 3 indicate that while Australians are living longer, the Royal Commission identified explicit ageism in both Australian society and the aged care sector. This study has further emphasised implicit ageism in policy. If the very sector tasked with caring for older individuals exhibits ageist practices and policies, addressing ageism in broader society becomes increasingly more challenging. Future studies could incorporate theoretical frameworks from Goffman, Foucault or Mol to gain a deeper understanding of the ontologies of individuals in residential aged care based on policy. Such research could provide valuable insights to inform and challenge the stigma and bias associated with this critical issue.

8.6 Conclusion

Through an explanatory sequential mixed-method design, this study has demonstrated that the language and terminology in the legislative pillars are important considerations when implementing person-centred models of care and that understanding how the language and nuance contained in these legislative pillars can lead to unexpected consequences and hinder the implementation efforts associated with new models of care in practice. The study’s findings have further revealed that the terminology and language in the legislative pillars seem to frustrate PCC model implementation. Despite their intent

of supporting quality of care and quality of life, the symbolic power and the associated posture of the regulator and forms connected with compliance requirements appear to work in opposition to that intent.

Through a Bourdieusian lens, the study has highlighted how the very pillars that are meant to support become dominant and superordinate, impeding the implementation of and shift to a more person-centred model, in direct conflict with the rhetoric of customer-centred-care that is predicated on choice and control. Bourdieusian frameworks helped this researcher understand how policy and legislative frameworks create symbolic power and symbolic violence in practice settings. These findings therefore demonstrate a number of considerations for people who lead the implementation of person-centred models of care; notably, that inadequate comprehension of legislative terminology and language can negatively impact PCC model implementation expressly designed to provide quality care and improve the quality of life for older people in practice settings. This lack of understanding risks perpetuating ageist stereotypes and prejudices, resulting in further stigmatising older people, sadly in the place where this should be the antithesis.

The findings of this study are significant and timely, with a new Aged Care Act due for implementation 1 November 2025. Since the legislation was passed, there has been considerable delay, as the DoHA continues to draft the subordinate legislation to the new Act, namely, the subordinate rules and principles that will help put the new Act into operation. Consequently, there is much debate and anxiety for both older Australians and providers associated with the ambiguity and delay as details and principles are made available for consultation and comment.

At the time of writing, there had already been another aged care sector taskforce to design aspects of the new legislation. New aged care policy and legislated review recommendations would benefit from considering past and existing efforts to implement policies, and the ways in which they may need translation and alignment to specific organisational context and practice settings.

This study has also contributed to and extended the literature with regards to the implementation of person-centred care models in residential aged care settings and wider social service settings and its applicability to other health and social care sectors and

across other government portfolios. The findings are applicable to other countries, based on the wide range of individuals interviewed for this study. Australia is not alone in reviewing aged care provision; the disproportionate impact of COVID-19 highlighted pre-existing systemic issues that require remediation in a number of countries (Bunting, 2020; Degenholtz et al., 2023; Sinha et al., 2025).

This study is the first to suggest a link between (and hence impact of) the language contained in government policy and legislation with regards to person-centred model implementation. The study has posited that the legislative pillars have, and continue to maintain, inordinate power over residential aged care, despite the rhetoric of “consumer”, “choice” and “control”. More importantly, the study has determined that the language of policy and legislative pillars needs to be considered when implementing PCC models. When policymakers extol the virtues of either PCC or “consumer”-centred approaches as the bedrock of quality care provision in residential aged care, these terms and their implications need to be explicitly defined as principles that guide practice. This is not to be a rule book or *fait accompli*, rather it is to underscore the uniqueness and individuality of each person, and that care is provided in and through relationships in practice settings not in a tick-box compliance privileged approach.

EPILOGUE

Reflexivity on the Findings of Power as a Practitioner

This final section is the last of the reflexive aspects outlined in section 4.6 and section 4.6.3 in particular. The research process is “ever present and recursive” (Day, 2012, p. 76). Bourdieu is particularly appropriate for reflexivity; his extensive body of work was founded on his principle of reflexivity. He consistently revisited various aspects of his studies, which added further depth to his interpretations of the social world and the theories that supported his work, often referred to as his “gaze” or “metanoia” (Grenfell, 2022).

This reflexivity and recursiveness have happened for me, given the change in my supervision panel, new people and new insights from reviewing and revisiting my findings. These have added an additional dimension to the findings and their application to practice and my personal growth.

Personally, as a practitioner leading PCC implementation in a variety of care settings, the findings from both phases of the study were considerations, personally, I wish I had been more aware of when I was leading these programs. I experienced disbelief so many times as I heard the perspectives regarding how the power of policy was perceived to be in direct contravention of the rhetoric or proposed approach to enhance quality of care and quality of life for older people. Perhaps I naively believed that our universal health care model was a safety net and was there to support the inherent dignity of all citizens, not dressed up as choice but constrained by regulatory and legislative bureaucracy, the “tick boxes”.

Consequently, I have a fresh appreciation for the challenges of frontline managers as they seek to deal with regulatory agencies and their associated compliance requirements. I have always believed in delivering quality of care to the highest standards and that if this is achieved, then quality and regulation will take care of itself. But the revelations associated with policy perversity and of the apparent sanctioned power and posture of the regulator, of the adversarial nature that this study has exposed, have challenged this belief and caused me to reconsider my approach, my own “metanoia”. These issues may have been exacerbated due to the COVID-19 pandemic and the Royal Commission, or in fact they may have been more endemic than I ever realised. I had always believed that good policy, best practice and proportionate regulation created care that reflects what we would want for ourselves and our loved ones, as Trigg promulgates, “the Mum test” (Trigg, 2018).

This research journey has not only enhanced my understanding of factors to consider in the implementation of person-centred models and their sustainability; it has also provided me with deep personal learning experiences associated with the research process. The journey and the results have also highlight other areas for in-depth focus and research.

Now I Become Myself

Now I become myself. It’s taken

Time, many years and places;

I have been dissolved and shaken,

Worn other people’s faces,

Now to stand still, to be here,

Feel my own weight and density!

The black shadow on the paper

Is my hand; the shadow of a word

As thought shapes the shaper

Falls heavy on the page, is heard.

All fuses now, falls into place

From wish to action, word to silence,

My work, my love, my time, my face

Gathered into one intense

Gesture of growing like a plant.

As slowly as the ripening fruit

Fertile, detached, and always spent,

Falls but does not exhaust the root,

So, all the poem is, can give,

Grows in me to become the song;

Made so and rooted so by love.

Now there is time and Time is young.

(Sarton, 1992)

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10. APPENDICES

10.1 Ethics Application

Human Ethics Application

Application ID :	ETH19-4553
Application Title :	Who do you say I am : Language, Culture and the Intersection with Quality and Safety in Aged Care
Date of Submission :	
Primary Investigator :	N/A
Other Personnel :	Prof Jo Francis Travaglia (Chief Investigator)
	Dr Deborah Suzannah Debono (Chief Investigator)
	Ms Linda Justin (SResearch Student)

Section 1: Ethics Portal

Select your application type

What type of application are you looking for?
Please **do not** change your application type without first consulting with the Ethics Secretariat (9514 9772).*

- (●) New application (including scope-checking for nil/negligible risk research)
- ( ) Ratification of existing approval
- ( ) Transfer of existing approval
- ( ) Evaluation of teaching and learning activities
- ( ) Amendment to existing approval
- ( ) Program approval

You have selected "new application (including scope checking for nil/negligible risk research)". This option allows you to create a new form. The system will check if your application can be approved by the Faculty or whether it requires full ethics approval by the HREC. Please click "save" before continuing.

What should I know before I start?

Would you like more information on:

- ( ) This system
- ( ) The ethics process
- ( ) Purpose of the ethics review process

This question is not answered.

Section 1A: Risk evaluation

Risk A

Determining the level of risk

For assistance with answering these questions please refer to the National Statement on Ethical Conduct in Human Research as per the chapters listed below.

You can save your application at any time by clicking on the save button on the left hand side in the toolbar. For further information and help in completing your application go to Staff Connect.

Please answer each question carefully **and consecutively.**

If you need to contact the Research Ethics Officer you can call (02) 9514 9772

Does your research involve:

Projects involving covert observation, active concealment, or planned deception of participants

e.g. covert observation of the hand-washing behaviour of hospital employees, undisclosed role-playing by a researcher, etc. Does NOT include observation in a public place WITHOUT the use of photographs, images, video or audio footage (Chapter 2.3, p.19)

*

- ( ) Yes
- (●) No

Targeted recruitment or analysis of data from any of the vulnerable groups listed below (or where any of these vulnerable groups are likely to be significantly over-represented in the group being studied)

- Women who are pregnant and the human fetus (Chapter 4.1, p. 61)
- Children and young people (under 18 years) (Chapter 4.2, p. 65)
- People in dependent or unequal relationships (e.g. lecturer/student [except T&L], doctor/patient, employer/employee) (Chapter 4.3, p.68)
- People highly dependent on medical care who may be unable to give consent Chapter 4.4, p.68)
- People with a cognitive impairment, an intellectual disability, or a mental illness (may include the disadvantaged/homeless) (Chapter 4.5, p. 70)
- People who may be involved in illegal activities (including those affected e.g. victims of domestic violence) (Chapter 4.6, p.73)
- Aboriginal and Torres Strait Islander Peoples (Chapter 4.7, p.77)

*

- ( ) Yes
- (●) No

People in / from countries that are politically unstable; where human rights are restricted; and/or where the research involves economically disadvantaged, exploited or marginalised participants from such countries e.g. includes countries that score <50 on the Transparency Index

*

- ○ Yes
- ◉ No

Collection, use or disclosure of personal information WITHOUT consent of the participant

- Name, address and other details about the participant (e.g. date of birth, financial information etc.)
- Photographs, images, video or audio footage
- Fingerprints

*

- ○ Yes
- ◉ No

Collection, use or disclosure of health information

- Personal information (as defined above) collected to provide, or in providing, a health service (e.g. admission to hospital, GP visit, pathology, pharmacy etc.)
- Information or an opinion about:

  (i) the health or a disability (at any time) of an individual; or
  (ii) an individual's expressed wishes about the future provision of health services to him
  (iii) a health service provided, or to be provided, to an individual

- Personal information about organ donation
- Genetic information about an individual or the individual's relatives

*

- ○ Yes
- ◉ No

Collection, use or disclosure of sensitive information

Racial, ethnic information, political, religious and philosophical beliefs, sexual activity or identity, and trade union membership

*

- ○ Yes
- ◉ No

Activity that potentially infringes the privacy or professional reputation of participants, providers or organisations

e.g. observation in the workplace, collection of commercially confidential information, etc.
Commercially confidential information = Any information which is not in the public domain or publicly available, and where disclosure may undermine the economic interest or competitive position of the owner of the information (TGA adopted definition from European Medicines Agency (EMA)).

N.B. if canvassing opinion via consensus methods i.e. Delphi (?), answer "No" here

*

- ◉ Yes
- ○ No

Establishment of a register, database, or databank of identifiable information for possible use in future research projects (Chapter 3.1, Element 4, pp.32-38)

*

- ○ Yes
- ◉ No

Collection, transfer and/or banking of human biospecimens.
e.g. tissue, blood, urine, sputum etc.

*

- ○ Yes
- ◉ No

Any significant alteration to routine care or service provided to participants

e.g. deviation from standard care or usual practice

*

- ○ Yes
- ◉ No

Prospective assignment of human participants or groups of humans to one or more health-related interventions to evaluate the effects on health outcomes (Chapter 3.14-3.17)

WHO definition of a Clinical Trial

*

- [ ] Yes
- [x] No

Potential for participants to experience harm

e.g. physical, psychological, social, economic and/or legal (Chapter 2.1, p.12)

*

- [ ] Yes
- [x] No

High Risk

Section 2: Project information

Project title

You can save your application at any time by clicking on the save button on the left hand side in the toolbar.
For further information and help in completing your application go to Staff Connect

Application ID (automatically generated):

ETH19-4553

Application Title:*

Who do you say I am: Language, Culture and the Intersection with Quality and Safety in Aged Care

Please note that the HREC is now granting a standard approval period for the research proposals.
The approval period for your project will be specified in your approval letter.
Please also note that research should not commence until ethics approval has been granted. The Committee cannot grant retrospective approval for data that has already been collected.

Ethics category code (automatically selected):*

Human

Is this a resubmission of a previous application?*

- [ ] Yes
- [x] No

Is this a pilot study? *

- [ ] Yes
- [x] No

Has a pilot study been conducted as part of this project? *

- [ ] Yes
- [x] No

Please save and continue to the next page

Consultation

You can save your application at any time by clicking on the save button on the left hand side in the toolbar.
For further information and help in completing your application go to Staff Connect

Have you undertaken any consultation in preparing this application?*

- [ ] Yes
- [x] No

Please save and continue to the next page

Section 3: Personnel

Investigators

You can save your application at any time by clicking on the save button on the left hand side in the toolbar.
For further information and help in completing your application go to Staff Connect

Are there external investigators or personnel listed on this protocol?*

- ○ Yes
- ◉ No

Is this application for a student project?*

- ◉ Yes
- ○ No

Students - Please note that once your application is submitted it will go directly to your supervisor and not to the Committee. Once your supervisor endorses your application it will come to the Research Ethics Officer for review. Your electronic application must be endorsed by your supervisor by the Research Office (LRO) submission deadline.

Personnel Table

Position type	In the personnel table use the following positions from the drop-down list
Chief Investigator	1Chief Investigator
Co Investigator	3Assoc. Investigator
Supervisor	1Chief Investigator
Co Supervisor	Co-Supervisor
Research Student	5Research Student

Further options are available for Research/Project Managers and Administrators.
The main contact should be marked as 'primary' and should be a UTS staff member.
Please click on 'More Criteria' located on the top right hand side of the table to find personnel.

If any details are incorrect or missing please contact the Ethics Secretariat on (02) 9514 9772 or by email.

Instructions on how to add a person to the personnel table:
1. Click on 'Add'
2. Start typing the details (first name, last name or Staff ID) in the search bar.
3. Click on "Add selected"

4. The extra information panel will open, enter the position. If they are the primary contact (e.g. Chief Investigator/Supervisor), tick "Yes" under 'Primary contact' and then select 'OK.

Students must add their supervisors to their application and must mark their primary supervisor as a Chief Investigator and as a primary contact. Students should be listed as "5Research student"

Internal personnel listed on this ethics protocol:

*

1	Primary	
	ID	128167
	Surname	Travaglia
	Given Name	Jo
	Full Name	Prof Jo Francis Travaglia
	Position	Chief Investigator
	Type	Internal
	AOU	FoH.Health Services Management
	Managing Unit	Faculty of Health
	Email Address	Joanne.Travaglia@uts.edu.au
	Work Number	+61 2 95144553
2	Primary	
	ID	129978
	Surname	Debono
	Given Name	Deborah
	Full Name	Dr Deborah Suzannah Debono
	Position	Chief Investigator
	Type	Internal
	AOU	FoH.Health Services Management
	Managing Unit	Faculty of Health
	Email Address	Deborah.Debono@uts.edu.au
	Work Number	+61 2 95145256
3	Primary	No
	ID	132645
	Surname	Justin
	Given Name	Linda
	Full Name	Ms Linda Justin
	Position	5Research Student
	Type	External
	AOU	FoH.Honorary
	Managing Unit	Faculty of Health
	Email Address	Linda.Justin@student.uts.edu.au
	Work Number	

If you cannot find a person through the personnel table(s) above, please enter their details here (title, name, organisation, department, phone number, address, email address and their position on this protocol). (4000 character limit)

This question is not answered.

Please provide additional (or preferred) contact details of any of the people listed on the project if necessary (4000 character limit)

This question is not answered.

Please provide details of any formal qualifications (REF NS 1.1(e)) of each person listed on the project (4000 character limit)*

Professor Joanne Travaglia PhD (UNSW), M.Ed (ACU), Grad Dip Adult Ed (UTS), B Soc. Studies (USYD) (Hons)
Dr. Deborah Debono PhD, BA (Psych Hons), General Nursing Certificate (RN), Midwifery Certificate
Ms Linda Justin, GAICD, M.Sc. Coach Psych (USYD) MBA (UNSW & USYD) BN (Hons) USYD

Please outline the experience of each person listed on this project relevant to this application (4000 character limit)*

Professor Travaglia is a sociologist with a background in health services research, management and leadership and is currently the Director of the Centre for Health Services Management at UTS. Professor Travaglia has authored, co-authored and or presented at over 250 articles, chapters, conference papers, seminars and workshops. She has supervised a number of Doctoral Students.

Dr Deborah Debono is a lecturer in the Faculty of Health at UTS. Her research seeks to inform improvement in health care at clinical, organisational and policy levels. She investigates quality improvement , patient safety and the influence of context, culture, technology and social relationships on clinicians' practice. Her work builds on her nursing and midwifery experience in rural and metropolitan acute care settings.

Ms Linda Justin is a clinician, executive and consultant who has led large scale transformational change programs nationally and internationally in Acute Care and Social care. She has been actively involved in advancing patient safety, clinical governance, clinical redesign and client centred approaches throughout her career. She is a regular conference presenter, author and is currently working with Dr Debono and Prof. Travaglia on a white paper regarding quality and vulnerable populations.

Primary AOU*

FOH.Faculty of Health

Managing Unit

Faculty of Health

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Student details

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Degree being undertaken (500 character limit)*

Doctorate

Have you been successful in your doctoral/masters assessment? *

○ Yes
◉ No

Please indicate why you are applying for ethics approval at this stage, and when you will be seeking assessment or re-assessment? (4000 character limit)*

Stage 1 assessment is scheduled for completion by Easter. Ethics approval is required to commence data collection as soon as possible after completion.

Students, please read carefully: Your application should be reviewed by the Ethics Secretariat prior to submitting to the Committee. Once you have completed this application and followed the submission instructions, your application will go to your supervisor for review. Once your supervisor has endorsed the application it will come to the Ethics Secretariat for a pre-review. This pre-review process is necessary to ensure that your application is complete, has all necessary attachments, and that the quality of responses to the questions meets the Committee¿s expectations. Your application should therefore be submitted at least one week prior to the closing date. If you do not submit your application in time, it may be delayed and held off until the next closing date.

Section 4: Funding

Funding details

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Have you received funding in relation to this research?*

○ Yes
◉ No

Do you intend to apply for funding in the future?*

○ Yes
◉ No

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Section 5: Methodology

Description

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The purpose of this section is to place your research in context for the HREC and demonstrate your ability to conduct the research. The HREC may only approve research which is methodologically sound. Remember to use simple language that can be understood by people from a variety of backgrounds. Avoid jargon and acronyms.

What are the hypotheses/goals/aims/objectives of your research? Please include a brief description using plain English explaining your research aims (approximately 100 words) (4000 character limit)*

The Ageing sector is undergoing intense public scrutiny into the instances of abuse and neglect through the Aged Care Royal Commission (ACRC). Aged care policy has shifted to reflect a greater focus on customer experience and quality of care. Providers are seeking to implement these policy changes and to transform their care delivery to meet changing customer expectations and demand profiles. How these improvement programs are designed and delivered from an organisational perspective varies.
This study aims to understand the organisational factors for transformation and how they have navigated the dynamic policy landscape. The purpose is to gather insights into design, approach, rationale, and the language and practice of aged care delivery.

Note: Clinical Trials, Recruitment of Participants and Data Collection are dealt with later so you will not need to describe them in detail below

Please provide a brief description of the research design including research questions and proposed methods for conducting the research (approximately 250 words) (4000 character limit)*

This study will be using mixed methods, sequential/iterative design approach to support and determine, utilising a discourse analysis perspective: how organisations can be focused on quality; if and how they choose to 'transform' their care practice delivery; and what are the essential elements that enable quality service provision in a coherent integrated fashion.
In particular this study seeks to understand:
1. How policy language and terminology translates to practice;
2. The organisational enablers of transformational change to enhance person-centred approaches;
3. How language influences practice throughout an organisation; and
4. To determine if language is aligned from Board to bedside, including what differences there may be between what is espoused and what is enacted.

The study's mixed methods approach will utilise:
Face to face or telephone interviews with Key Leaders in Aged Care in Australia and Academics/Thought leaders in the USA, UK, and Canada. The primary research method will involve semi-structured interviews of key leaders within organisations in Australia who have delivered change over the last seven years, to ascertain the lessons learnt, and the complexity associated with the change journey with aged care providers. In addition, interviews with a number of international leaders and academics who have studied person-centred change. A purposive sample of key leaders and academics has been influenced by both the research questions and the practical considerations of delivering change to enhance practice. The sample will have a degree of heterogeneity to enable analysis and review practice in concert with the observation methods.
An analysis of key organisational documents as available on provider websites, and where possible agendas for Board, Executive and Service level meetings; and
Direct observation of artefacts in aged care practice settings utilising a validated tool, Artefacts of Cultural Change (Bowman and Schoeneman).

What do you hope the outcome(s) of this research will be? (4000 character limit)*

The outcome will be a greater appreciation of the complexity and enablers associated with change programs in large, complex, geographically dispersed practice settings.
Culture within organisations is becoming increasingly more topical as a consequence of various Royal Commissions. This research will provide practical insights for Boards and Executives in the Social Care sector from a governance and practice perspective regarding language and culture.
This alignment from Board to service delivery for Vulnerable populations removes a perceived disconnect regarding head office and practice.
Finally, Government and regulators will benefit from this research as there will be a greater awareness of the import of language and terminology when changing policy. The impact on provider and ultimately practice delivery and the associated community expectations implicit with language

Who do you think will benefit from this research? (4000 character limit)*

Providers will benefit as this research provides greater awareness of the organisational enablers of cultural change including how language and measures influence and enable these changes at all levels of the organisation.
Policy Makers will benefit as the results of this study have the possibility to add to how policy is formulated, disseminated and implemented.
People-Those accessing Aged care will benefit from there being greater understanding and consistency regarding those providers engaged in practice enhancements and how language influences practice change. This will assist with provider selection.

Please provide a brief description of the significance of your research (approximately 100 words) (4000 character limit)*

The Aged Care sector is at a significant juncture in its maturity. The Aged Care Royal Commission is highlighting many issues regarding the quality and practice of care, and indeed in relation to society's attitude towards ageing. Quality and Safety improvement programs have achieved moderate successes, and the language used and its intersection with practice can be a major contributing factor to this important issue. An examination of the language, meaning and power of the transformation discourse in this volatile field at a time of significant scrutinization, may provide some valuable insights into the underlying change process.

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Literature review & references

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Please give a brief literature review. The aim is to explain how your research fits into the context of other research in the area (REF NS 1.1(c)) (4000 character limit with spaces)
Please note that you cannot paste links into the online form
*

How we think about quality and safety determines what we prioritise and value. Therefore, the successful implementation of quality improvement programs require organisations to collectively see quality as a component of culture and as an organisational competency. (Braithwaite, Herkes, Ludlow, Lamprell, & Testa, 2016; Kaplan et al., 2010; Powell, Rushmer, & Davies, 2009). This sets a new direction for the aged care sector, one which demands a more comprehensive understanding of what quality service delivery actually comprises beyond that of meeting basic compliance standards.(Barron & West, 2017). The Royal Commission into Aged Care Quality and Safety (ACRC) has provided an impetus to review the determinants of quality and safety and the enablers of cultural change to support these. The issues of perceived abuse and neglect are multifactorial and highlight an interplay of several factors from the ageing process; policy formulation; organisational delivery, organisational culture and language.
In reviewing health and social care policy a number of terms are used interchangeably, Patient, Customer, Client, Consumer, Resident or Care Recipient. The definitions associated with each of these terms add to the potential misalignment between expectations of the Government to consumer, business (provider) to consumer, and even consumer to consumer. Many of these terms have been driven by policy approaches such as neo-liberalism (Angus & Nay, 2003; Le Grand, 2007), creating inherent tensions for providers as they seek to apply these policy directions within service provision, perpetuating and aggravating the disconnect for people as they seek to provide what should ostensibly be a relational and social model of person centred care.
The multiplicity of terms in use, their associated ambiguity and their implications for practice provides a potentially emerging area for wider study (Karlin, Emick, Mehls, & Murry, 2006) particularly when considered with the associated intersection on culture and quality (Barbato & Feezel, 1987) and their utility to support or adversely impact organizational enablers of culture change (Petriwskyj, Parker, Brown Wilson, & Gibson, 2015; Tuckett, 2006; Wasserman & McNamee, 2010).
If the culture we walk past, is the culture we accept, and language drives culture and behaviour within organisations, is the language we use perhaps the missing link to enterprise quality service aged care delivery? Schein outlines how culture operates at three levels: artefacts and behaviours, values and principles and assumptions (Schein, 2010).
Therefore, there exists an opportunity to investigate from a discourse analysis perspective, the intersection and impact on personhood and quality in the aged care sector.

Please list the references only used in the literature review and cited in your application
NOTE: Do not include references you have not used in this application (4000 character limit)
*

Angus, J., & Nay, R. (2003). The paradox of the Aged Care Act 1997: the marginalisation of nursing discourse. Nursing Inquiry, 10(2), 130-138.
Barbato, C. A., & Feezel, J. D. (1987). The language of aging in different age groups. The Gerontologist, 27(4), 527-531.
Barron, D. N., & West, E. (2017). The quasi-market for adult residential care in the UK: Do for-profit, not-for-profit or public sector residential care and nursing homes provide better quality care? Social Science & Medicine, 179(Supplement C), 137-146.
Braithwaite, J., Herkes, J., Ludlow, K., Lamprell, G., & Testa, L. (2016). Association between organisational and workplace cultures, and patient outcomes: systematic review protocol. BMJ Open, 6(12). doi:10.1136/bmjopen-2016-013758
Kaplan, H. C., Brady, P. W., Dritz, M. C., Hooper, D. K., Linam, W., Froehle, C. M., & Margolis, P. (2010). The influence of context on quality improvement success in health care: a systematic review of the literature. The Milbank quarterly, 88(4), 500-559.
Karlin, N. J., Emick, J., Mehls, E. E., & Murry, F. R. (2006). Comparison of efficacy and age discrimination between psychology and nursing students. Gerontology & geriatrics education, 26(2), 81-96.
Le Grand, J. (2007). The Politics of Choice and Competition in Public Services. The Political Quarterly, 78(2), 207-213.
Petriwskyj, A., Parker, D. B. A., Brown Wilson, C., & Gibson, A. (2015). What Health and Aged Care Culture Change Models Mean for Residents and Their Families: A Systematic Review. Gerontologist, 56(2), e12-e20.
Powell, A., Rushmer, R., & Davies, H. (2009). A systematic narrative review of quality improvement models in health care: NHS Quality Improvement Scotland.
Schein, E. H. (2010). Organizational culture and leadership (Vol. 2): John Wiley & Sons.
Tuckett, A. G. R. N. M. A. P. (2006). On paternalism, autonomy and best interests: Telling the (competent) aged-care resident what they want to know. International journal of nursing practice, 12(3), 166-173.
Wasserman, I. C. P., & McNamee, S. P. (2010). Promoting compassionate care with the older people: a relational imperative. International Journal of Older People Nursing, 5(4), 309-316.

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Methods and methodologies

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In order to consider your research, the HREC will need to know what it will involve for your participants (REF NS 3.1)

What kinds of methods and methodologies will you use in your research? (More than one box may be checked)*

- ☑ Quantitative
- ☑ Qualitative

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Quantitative

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Section 1: Quantitative Methodologies*

- ☐ Experimental
- ☐ Quasi-experimental
- ☐ Correlational research
- ☐ Survey Design
- ☐ Meta analysis
- ☑ Other *(Please describe below)

Please describe other methodologies (1500 character limit)*

Content analysis may be qualitative or quantitative. Both can use the same body of textual and other data. Most content analysis is now entirely quantitative. It counts the incidence and frequency of words. Its theoretical underpinning is provided by Zipf's Law - an experimental law developed by George Zipf (1902-50). What Zipf means in plain English is that, where uncommon words (or phrases) are used often in a text, then they express and reflect the greatest concerns of the communicator. These are termed key words. Substantive content analysis analyses selected texts by counting the frequency and distribution of key words.

Section 2: Quantitative methods*

- ☐ Written survey
- ☐ Online survey/research
- ☐ Other* (please describe below)
- ☐ Pre-post/testing
- ☐ Telephone survey
- ☐ Questionnaires
- ☐ Access to records
- ☐ Clinical trial
- ☐ Statistical analysis
- ☑ Content analysis
- ☐ Physiological testing/assessment

What **quantitative** methodology and methods will you be using in this research? More than one box may be checked.

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Qualitative

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What **qualitative** methodology and methods will be using in this research?

Section 1: Qualitative methodology*

- ☐ Auto-ethnography
- ☐ Historical research
- ☐ Other *(Please describe below)
- ☐ Action research
- ☐ Narrative enquiry
- ☐ Biographical research
- ☐ Case study
- ☐ Phenomenology
- ☐ Indigenous research paradigm
- ☑ Discourse analysis
- ☐ Grounded theory

Section 2: Qualitative methods*

- ☑ Participants observation
- ☐ Covert observation
- ☐ Life story or oral history
- ☐ Focus groups
- ☐ Structured interviews
- ☑ Semi-structured interviews
- ☐ Unstructured interviews
- ☐ Other * (Please describe below)
- ☐ On-line research
- ☐ Psychological testing/assessment
- ☐ Verbal protocol
- ☐ Journaling
- ☑ Artifact analysis
- ☑ Document/Policy analysis
- ☐ Access to records
- ☐ Audio/video recording

Please describe how participant observation will be conducted, including how many participants will be involved (from each participant group (if there is more than one group/cohort), the amount of time required of participants for this, whether it will be recorded, and any other information applicable (4000 character limit)*

The participant observation will be conducted when observing the aged care practice setting. This ethnographical approach will be conducted utilising a validated tool, Artefacts of Cultural Change (Bowman and Schoeneman) as a framework for the observations. This tool is available for public use in the USA, supported by the Centers for Medicare and Medicaid and used by a Peak body -the Pioneer Network to benchmark provider members transformation 'change journey'. The tool has been researched and supported by the Commonwealth Fund. The tool reviews artefacts that are deemed by the authors to support person centred care in practice. The tool will guide the researchers observations which will be scored against the artefact domains within the tool. Whilst completing the tool, the researcher will be listening to and observing and documenting the language used to describe people and care delivery within the practice setting. Aged Care whilst a practice setting is not a health service by definition under the Aged Care Act 1987.

Please describe how interviews will be conducted, including how many participants will be involved (from each participant group if there is more than one group/cohort), the amount of time required of participants for this, whether it will be recorded, and any other information applicable (4000 character limit)*

Group 1. Interviews will be semi-structured of approx. 60 minute duration. Interviews will be recorded, and transcribed. The participants will be CEO's and key leaders from the Aged Care Sector, approximately 20 CEO's. or C-suite Executive who have led or been involved in the 'transformation' of Care delivery. The interviews will be where possible face to face or will utilise non face to face mediums I.e. Skype or Zoom.
Group 2 Interviews: Four International Academics and/or Change leaders will be interviewed regarding their insights into cultural change. These international thought leaders and academics are known to have researched, and or developed change programs for aged care in the UK, Canada and the USA to enhance practice. Interviews will be semi-structured of approx. 60 minute duration. Interviews will be recorded, and transcribed. The interviews will be where possible face to face or if this is not possible they will utilise non face to face mediums I.e. Skype or Zoom.
During the service reviews, individuals (care workers and site managers) will be asked to describe care within the practice setting or to answer some of the questions that are not immediately observable when reviewing the artefacts. A separate document is attached to outline the research methods.

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Section 6: Research participants/subjects part 1

Recruitment of participants

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**In line with the National Statement, the definition of participants includes not only those humans who are the primary focus of the research but also those who will be affected by the research.
The HREC regards the principle of respect for persons as of paramount importance.
(REF NS 1.1 (d), 1.6-1.9, 1.10, 2.1).**

How will you initially select and contact your participants? More than one box may be checked, if appropriate*

- ☐ Advertisement/flyer
- ☑ E-mail
- ☑ Telephone
- ☐ Internet
- ☐ Organisation
- ☑ Personal contact
- ☑ Letter
- ☐ Other contact method to be used

Outline how you will obtain participants' contact details and what your recruitment process will be (4000 character limit)*

Stage 1 interviewees will be identified through either or both the Peak Body for one large federated provider of Aged care. Others will be identified through public domain registers of Aged Care providers. The Researcher will contact the CEO at the peak body/ each provider using the publicly available details working with them to gain institutional approval where required. These invitations will note that participation is voluntary. Invitation or calls for participants will outline that there are participant information sheets available or attached with details of the Researcher. It is anticipated that through the purposive sampling others known to the interviewees and deemed to be of interest to the research questions and topic under research will be suggested.
Stage 2 Interviewees contact details will be identified through public domain registers or literature.

Please describe your recruitment plan/strategy

The researcher is known within the sector and also knows which providers have been involved in person centred transformational change programs. This approach is consistent with the purposive sampling technique which is being utilised. Therefore, the Researcher will directly approach through UnitingCare Australia, to CEO's and Board members, and others within the sector. Through these interviews other participants may be identified.
International academics and authors will be directly contacted and approached.

How many participants do you intend to recruit? (If you are intending to recruit different groups of participants, please answer all relevant questions for each group, e.g. control group, test group, etc)
(4000 character limit)*

The researcher expects to recruit a maximum of 20 respondents for the first stage (qualitative).
This recruitment target is the result of a purposive sampling approach which has been selected to provide the ability for the researcher to purposively invite aged care providers of varying size and motive (for profit, not for profit) and to gain access to various respondents of seniority and function (c-suite/or Board).
This sample will be geographical dispersed across Australian States and Territories so as to sample those who have characteristics or experience most relevant to the research objectives. Although not designed to be nationally representative, this sampling strategy allows for the inclusion of a diverse group of Aged Care service providers.
The Second group of interviewees will be international Academics or Thought Leaders who have researched or studied cultural change within aged care internationally. These leaders will be sourced from the USA, Canada and the UK. The number will be 8 in total.
The interviewees from the site visits will be directly related to the number of people on shifts or time of day. The Artefacts tool and observations will guide who is interviewed.

Explain how and why you have chosen this number (If the research is quantitative, explain the power calculations; if the research is qualitative, explain why the proposed number is likely to result in adequate data) (4000 character limit). For guidance, see how to address sample size here.*

Qualitative: Data saturation informs sample size in qualitative research making it difficult to determine exact sample size. Ongoing analysis of the data will determine when data saturation as it occurs. Data collection will be limited or stopped when the data being collected does not demonstrate significant new issues or questions and broadly conforms with themes and patterns and observations that develop throughout the research process. While the study will rely on the saturation of emerging concepts to determine the final sample size and estimated maximum of 20 interviews is expected.
Quantitative: 1. The initial questions from the interviews regarding the Aged care providers are descriptive providing contextual information. For this reason, calculation of sample size is not required. Other Quantitative methods, 2. Content Analysis method perspective the research will review communication tools such as;- publicly available web-site, vision, mission and values statements, strategic documents and person-centred information tools such as brochures. These main documents provide the frame for the content analysis. 3. The Artefacts cultural change tool will provide quantitative data regarding the practice environment, care practice environment, how food is delivered, birthdays are celebrated, personalised routines, family involvement, leadership artefacts, and consistency of staffing.

Describe your inclusion and exclusion criteria for participants (4000 character limit)*

Inclusion and Exclusion criteria apply to all participants. Participants are eligible to participate if they have led or studied/researched transformational cultural change programs in aged care.

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Participant involvement

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What time commitment will the research involve for your participants?
NOTE: This information must be included in any information to participants
(4000 character limit)*

Interview duration is anticipated to last up to 60 minutes.
Observational elements will involve the researcher from an ethnographic perspective understanding the practice setting for the people who live there and those who deliver care, walking through to note artefacts associated with the practice delivery setting- and contextual information such as brochures, websites, mission statements, artefacts such as service layout, décor, logos and branding, dress, rituals and ceremonies and reviewing agendas of meetings where possible.

In what location will the research/data collection take place?
NOTE: This information must be included in any information to participants
(4000 character limit)*

Qualitative: The majority of data collection will take place where possible in person, or via skype / Zoom or other VOIP enabled face to face tool, in the private offices where the participants work. If only remote access is required due to distance the researcher will be located in UTS offices or other private space due to international time differences to ensure privacy.
Quantitative data -direct observation of practice setting using the Artefacts questionnaire is required to take place on site. Contextual aspects such as web-sites and brochures, mission statements will be reviewed remotely in a private space at UTS.

What travel, if any, does the research involve for your participants?
NOTE: This information must be included in any information to participants
(4000 character limit)*

There is no travel for participants.

Please include any additional information relating to participants that you think relevant
NOTE: This information must be included in any information to participants
(4000 character limit)*

Nil

Describe and justify any benefit, payment or compensation the participants will receive. For research being conducted with Aboriginal and Torres Strait Islander People, the described benefits from research should have been discussed with and agreed to by the Aboriginal or Torres Strait Islander research stakeholders. (REF NS 2.1) and 4.7.8 & 4.7.9)
(4000 character limit)*

There will be no compensation for participants. A letter thanking participants individually and the UntingCare network will be forwarded to each site at the conclusion of field work.

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Consent

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Will you be obtaining written consent?*

◉ Yes
○ No

Please provide sample documents in attachments list at the end of the application form
Please use the following HREC templates when creating an information sheet and consent form: HREC templates

Do you believe there will be any special issues relating to consent in your research? (REF NS 1.13, 2.2, 2.3, Chapter 4)*
- ○ Yes
- ◉ No

Are the participants able to consent fully? (REF NS Chapter 2, 4.4, 4.5)*
- ○ Yes
- ◉ No

Please give details (4000 character limit)*

The Organisation will be required to consent on behalf of the facility or service where the direct observation utilising the Artefacts of Cultural change tool is utilised as a method for the observation.

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Limited disclosure

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Does this research involve limited disclosure to participants? (REF NS 2.3)*
- ○ Yes
- ◉ No

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Vulnerable populations

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Indicate if your research will involve the following vulnerable populations (as per the National Statement) other than as incidental participants (i.e. they are not included in the design of the project but may be participants) (REF NS Chapter 4)
*

- ☐ Women who are pregnant and the human foetus
- ☐ Children and young people
- ☑ People in dependent or unequal relationships
- ☐ People highly dependent upon medical care who may be unable to give consent
- ☐ People with a cognitive impairment, an intellectual disability or a mental illness
- ☐ People who may be involved in illegal activities
- ☐ People who are incarcerated
- ☐ Aboriginal and Torres Strait Islander Peoples
- ☐ People in other countries
- ☐ None of the above

Describe how you will respect the ethical considerations specific to your participants, in accordance with Chapter 4 of the National Statement (4000 character limit)*

Whilst Aged care facilities are not hospitals or health services, the people who reside and work there are in dependent or unequal relationships in reality or potentially. The Researcher will ensure that there is no breech of confidentiality, impediment to care delivery in the normal course of practice delivery whilst observing the practice setting. Involvement is voluntary. The Researcher will also not be providing specific identifiable information to Managers or Leaders.

If your research is being conducted in Australia, does it involve Culturally and Linguistically Diverse (CALD) People?*
- ○ Yes
- ◉ No

Do you intend to recruit any members of the Australian Defence Force?*
- ○ Yes
- ◉ No

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Section 7: Research participants/subjects part 2

Risk/harm

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Risk or harm could be described as damage or hurt to the wellbeing, interests or welfare of an individual, institution or group. Harm could range from physical hurt or damage such as illness or injury, to psychological or emotional hurt or damage, such as embarrassment or distress. Please note that as a researcher, you are not necessarily immune from risk yourself and should give careful consideration to this question (REF NS 2.1). For help in addressing the risk/harm section please click here.

NOTE:
It is **really** important that you carefully consider all ***potential*** risks that could occur, even if they seem negligible.
Please **do not** provide one-word answers to any of the questions below.
Please refer to the guidelines to address risk and harm located on the UTS HREC website titled: Help for how to address the risk/harm section.
Describe, as best as you can, any possible risks to research participants, subjects and related groups
NOTE: This information must be included in any information to participants (4000 character limit)*

There is not considered to be any likelihood of physical harm occurring as a result of this study. There is a slight risk that participants may not want to discuss change or issues due to the heightened external environment associated with concurrent Aged Care Royal Commission.

How would you categorise the magnitude of potential risk? (e.g. inconvenience, discomfort, harmful, painful)
Explain why you believe this is so (4000 character limit)*

The risk of a reputational issue is potentially harmful if identified, but no directly identifiable information will be collected.

How would you categorise the likelihood of risk? (i.e. slight, possible, likely, probable, unavoidable)
Explain why you believe this is so (4000 characters)*

Slight. Participants are managers, c-suite executives and Board members who have received letters and emails informing them that their participation is entirely voluntary. For this reason, it is unlikely that a participant who is uncomfortable discussing change will be uncomfortable. They may also feel it is a worthwhile study to be involved in given the external environment. The semi-structured exploratory nature of the questions means that participants are able to elect not to disclose issues that they perceive are of a reputational nature.

What strategies will you use to minimise and/or manage the risks? (4000 character limit)*

Participants will be informed that their consent in the study is entirely voluntary, and they may withdraw from the research at any time should they wish to do so.
In reporting these data, the researcher will balance accurate representation of findings with sensitivity to the organisations and professionals in any publication. This is supported by the research question which is about understanding and eliciting the organisational enablers of person-centred transformational change and their experience of leading said change from a thematic perspective. In addition, the research information sheet notes these strategies, whilst also noting that from an industry perspective that 100% confidentiality is not possible, despite removing all identifying characteristics and reporting results in an aggregated and thematic analysis. Whilst the data must be collected at the individual level it will be reported at aggregated and thematic level with no individuals or organisations identifiable.

Discuss likely or possible risk to researchers (including yourself), and your strategies for minimising such risks (4000 character limit)*

The risk to the researcher is unlikely. The researcher will attempt to establish a professional rapport with interviewees to encourage a positive interaction. The researcher is also aware that they too have the option to terminate the interview is they are experiencing discomfort or observing practices that are inconsistent with accepted standards.

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Pre-existing relationships

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Are there likely to be any pre-existing relationships with research participants? (e.g. employer/employee, colleague, friend, relation, student/teacher, etc)*

- (●) Yes
- ( ) No

Please describe (4000 character limit)*

The researcher has worked in and or consulted across the health and Social Care sector through the course of their professional career. Therefore some participants may have worked with or alongside her in the course of their professional interactions.

How might these relationships influence their decision to participate, be affected by the proposed research or create potential ethical conflict? Please describe strategy for dealing with this (4000 character limit)*

These relationships could cause an unintentionally coercive effect in relation to both informed consent and the frankness of the qualitative data collection by interview. For this reason, the researcher will not interview in the organisation in which she has previously worked in the recent past. In addition, where possible communications will acknowledge the peak body to support broader individual confidentiality but attribute their involvement. The researcher will emphasise the voluntary nature of participation both for individual providers and the peak body.

Describe how you will ensure that student assessment, employee security, etc., will not be adversely affected by participation in this research (4000 character limit)*

This research does not evaluate student or employee performance. No students will be interviewed in the course of this study. After gaining approval, the researcher will be inviting participation directly with C-suite and Board Members. These key leaders will then identify the practice are for the observational aspect.

Will you be recruiting UTS staff and/or students as research participants?*

- ○ Yes
- ◉ No

Please save and continue to the next page

External organisations

You can save your application at any time by clicking on the save button on the left hand side in the toolbar.
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Indicate if your research will involve any of the following:*

- ☐ Institution
- ☑ Organisation
- ☐ Community Group
- ☐ None of the above

Please describe what type(s) of institution / organisation / community group will be involved and how many will be involved (4000 character limit)*

This research project will involve key leaders in the Australian Aged Care Sector.

Was the research generated from within the institution / organisation / community group?*

- ○ Yes
- ◉ No

Please save and continue to the next page

External organisation consent

You can save your application at any time by clicking on the save button on the left hand side in the toolbar.
For further information and help in completing your application go to Staff Connect

Have you sought appropriate approval or support from the institution / organisation / community group involved?*

- ○ Yes
- ◉ No

Do you intend to?*

- ◉ Yes
- ○ No

Please provide evidence when obtained

Do you intend to feed the research results back to the institution / organisation /community group?*

- ◉ Yes
- ○ No

Does this research involve any contracts, including confidentiality agreements? (REF NS 3.2.12, 3.5.6) (Section 2.5 and 4, The Code)*

- ◉ Yes
- ○ No

Is your contract finalised?*

- ◉ Yes
- ○ No

Please detail any particular conditions that might have ethical implications for the research (e.g. access to data, publication, etc) **NOTE: You should attach an electronic copy of your contract to your ethics application** (4000 character limit)*

No ethical considerations are identified.

Please save and continue to the next page

Section 8: Data

Data collection

You can save your application at any time by clicking on the save button on the left hand side in the toolbar.
For further information and help in completing your application go to Staff Connect

The collection, storage and use of data involve important considerations of privacy. When collecting data, researchers should show due sensitivity and respect for persons. It is also important that data be reliable, authentic, and where appropriate, replicable. This section will provide the HREC with information as to how you intend to deal with these issues.
(REF NS 2.2.6(f), 3.2) (Section 2, The Code)

Who will collect the data? (More than one box may be checked) (Section 2, The Code)*

- ☐ External contract researcher
- ☐ External associate researcher
- ☐ External student
- ☐ Internal (UTS) academic researcher
- ☐ Internal (UTS) research assistant
- ☑ Internal (UTS) student
- ☐ Research Assistant
- ☐ Volunteers
- ☐ Other

Will you be attaching a sample of your data recording/measurement instrument(s) to this application (e.g. survey, interview format, etc?)*

- ◉ Yes
- ○ No

Please save and continue to the next page

Information database or personal records

You can save your application at any time by clicking on the save button on the left hand side in the toolbar.
For further information and help in completing your application go to Staff Connect

Do your data collection or recruitment methods include access to an information database or personal records?
(Section 95 and 95A, Privacy Act) (REF NS 3.2)
*

- ○ Yes
- ◉ No

Please save and continue to the next page

Data type

You can save your application at any time by clicking on the save button on the left hand side in the toolbar.
For further information and help in completing your application go to Staff Connect

The HREC is required to report on privacy to the Federal and NSW Privacy Commissioners

Indicate the category of data you will be obtaining at the point of data collection (More than one box may be checked):*

- ☐ Individually identifiable data
- ☑ Re-identifiable data
- ☑ Non-identifiable data

Are you obtaining consent for individually identifiable or re-identifiable information?*

- ◉ Yes
- ○ No

Please select how you will be obtaining consent from the list below*

Written consent

Why do you need to have access to individually identifiable and/or re-identifiable data? (4000 character limit)*

Interview and other contextual data collected by the researcher will not contain in as much as the participants may use names etc or have mannerisms which could be identifiable data-these can will be deleted at transcription- though they may be reidentifiable through linking to other records. The aim is to understand the organisational enablers of person-centred culture change and that change at a practice level particularly in language and artefacts. Thefore these data must be collected at the individual but will be reported at the aggregated level, the resulting thematic analysis with no individuals, services, provider ownership idenitifable in publications. Unique information that might potentially identify particpants or providers will be carefully framed, disguised or omitted from any publication associated with this research.

Will you be seeking identifiable information from a Commonwealth agency, without the consent from the individuals to which the data refer?*

- ○ Yes
- ◉ No

How will you ensure that data will be non-identifiable? (4000 character limit)*

Please see above.

Please save and continue to the next page

Data storage

You can save your application at any time by clicking on the save button on the left hand side in the toolbar.
For further information and help in completing your application go to Staff Connect

Data must be stored and secured for a minimum of 5 years after publication (Some data are required for longer periods of time and the storage will need to take this into account). For further details on retention requirements, refer to the UTS Records Management Policy http://www.records.uts.edu.au/policies/index.html
The data should be stored so as to ensure maximum privacy for participants, reliability and retrievability of data.

Indicate the format(s) the data will be stored in (Choose as many categories as applicable)
NOTE: This information must be included in any information to participants
*

- ☑ Electronic/digital recording
- ☑ Handwritten notes
- ☐ Microfilm
- ☐ Non-identifiable(anonymous)data
- ☐ On-line data storage
- ☐ Paper questionnaires/Surveys
- ☑ Transcripts of tapes/recordingd
- ☐ Video tapes
- ☐ Other

Who will have access to the raw data? (Choose as many categories as applicable)
NOTE: This information must be included in any information to participants
*

- ☐ UTS academic researcher(s)
- ☑ UTS student(s) and supervisors
- ☐ External researcher(s)
- ☐ Research assistant(s)
- ☐ Funding body/organisation
- ☐ Partner organisation(s)
- ☑ Other

Please give details (4000 character limit)*

Commercial transcription agencies may have access to raw data for the purposes of transcription. Confidentiality agreements will be executed with these agencies.

Please save and continue to the next page

Use & publication of data

You can save your application at any time by clicking on the save button on the left hand side in the toolbar.
For further information and help in completing your application go to Staff Connect

How do you intend to use and/or publish the data? (Choose as many categories as applicable)
NOTE: This information must be included in any information to participants
*

- [x] Book
- [ ] Client Report
- [x] Conference paper
- [x] Electronic publication
- [ ] Media
- [ ] Report
- [x] Thesis
- [x] Journal articles
- [ ] Other

Do you envisage any additional use of data in future research projects?*

- ○ Yes
- ◉ No

Please save and continue to the next page

Privacy principles

You can save your application at any time by clicking on the save button on the left hand side in the toolbar.
For further information and help in completing your application go to Staff Connect

As a general principle, privacy and confidentiality should be respected at all stages of the research (raw data, analysis, published or archived), and by all those involved in the research (including the researcher, research assistants, administrative assistants, students, interpreters, translators, data processors, members of focus groups, etc.)

Note: Privacy and confidentiality is complicated in NSW because it is governed by a number of separate Acts. From 12 March 2014, the new Australian Privacy Principles (APPs) were introduced to regulate the handling of personal information by Australian government agencies and some private sector organisations.

The privacy fact sheet providing the text of the 13 APP can be accessed here.

The 13 APP apply to all research conducted by staff and students of this University.

Will this research be undertaken in conformity to ALL the Privacy Principles?*

- ◉ Yes
- ○ No

Please save and continue to the next page

Privacy & confidentiality

You can save your application at any time by clicking on the save button on the left hand side in the toolbar.
For further information and help in completing your application go to Staff Connect

How will you ensure the security of the data? (4000 character limit)*

Electronic records will be stored in a secure password Data storage service , accessible only to the research student and supervisors. Paper records will be stored in a secure cabinet in the Centre for Health Management, Faculty of Health on the UTS Broadway campus, accessible only to the researcher and UTS Supervisors. Data will be entered into the analytical software for analysis by the researcher. Handwritten notes from observations will be transcribed for analysis will be stored on a secure password protected Data Storage service accessible again to the researcher and Supervisors.

How will you protect the confidentiality/privacy of your participants? (4000 character limit)*

All data and consent forms will be returned to UTS and stored there in a secure cabinet in the Centre for Health Management, Faculty of Health on UTS Broadway Campus. No individually identifiable data will be stored. Only the researcher and Supervisors will have access to the data and will only access these to address the aims of this study.

To what extent will you or anyone else be able to identify the research participants from the published or unpublished data? Please describe: (4000 character limit)*

The Aged sector in Australia is significant in scale though highly affiliative, therefore there is some risk that those who read publications which use the data may recognise the provider or some key leaders who have participated. This carries a risk to the confidentiality of the participants, as well as risk to their reputation if the publications contain adverse comments. All reports, publications or presentations from this research study will present the data in a summarised, thematic format in order to reduce the risk of identification.

Please save and continue to the next page

Interpretation/analysis/disposal

You can save your application at any time by clicking on the save button on the left hand side in the toolbar.
For further information and help in completing your application go to Staff Connect

Regardless of whether data collected is qualitative or quantitative, how do you plan to analyse these data into material that is valid and reliable? (Include a brief summary of your Analysis Plan)
(4000 character limit)*

Qualitative questions: data will be transcribed and thematic analysis undertaken to identify patterns, particularly those related to facilitators and barriers using qualitative analysis software and techniques (eg NVivo). Content and other analyses utilising digital humanities methods visualisation, data mining and text analysis, network analysis) may be undertaken on transcribed data.
Quantitative -Contextual Aspects will be summarised and themed, to determine patterns in the research in the aggregate. If sufficient variation is seen and data quality is consistent, groups of themes on artefacts, (such as vision statements, values lists, agendas from meetings) or provider typologies (For profit/not for profit) will be descriptively compared and non-parametric statistical tests applied to explore the themes and typologies.

Will the data be archived or destroyed? *

- [x] Archived
- [ ] Destroyed

Where will the data be archived, who will have access to it, and will there be any conditions attached?
(4000 character limit)*

Data will be archived in hard copy and electronic formats. These will be stored in locked cabinets at the Centre for Health Management, Faculty of Health UTS within locked staff offices in secure zones of the university. Electronic data (e.g. transcripts and coded transcripts will be stored on UTS based servers on a secure drive.

Please save and continue to the next page

Section 9: Additional information

Other ethical issues

You can save your application at any time by clicking on the save button on the left hand side in the toolbar.
For further information and help in completing your application go to Staff Connect

If there are any additional ethical issues which you do not believe have been covered by this form, please explain them for the HREC: (4000 character limit)*

Nil

Please save and continue to the next page

Section 10: Attachments

Attachments

You can save your application at any time by clicking on the save button on the left hand side in the toolbar.
For further information and help in completing your application go to Staff Connect

I have attached the following supporting documents

Relevant contracts/agreements*

- ○ Yes
- ◉ N/A

Informed consent form(s)*

- ◉ Yes
- ○ N/A

Participant Information Sheet(s)*

- ◉ Yes
- ○ No

Survey(s)/questionnaire(s)/outline of question(s)*

- ◉ Yes
- ○ N/A

Explanations of any technical terms used*

- ○ Yes
- ◉ N/A

Standard Operating Procedures

N.B. May include a distress or disclosure protocol [see UTS HREC Disclosure Guidelines], Faculty of Health Low Risk protocol; procedures for participant screening, physiological, or biological sampling and/or laboratory or safety procedures where relevant.

*

- ○ Yes
- ◉ No

Please explain why any of the above items have not been attached (either softcopy/hardcopy) and when they will be provided (4000 character limit)*

There are no technical terms used in the application, as such a glossary has not been provided.

NOTE: If you are only attaching a hardcopy of any attachments relating to this application, you must still click on 'Add'.
If possible, please consolidate all attachments into one PDF

How to attach

Click on "Add"

Ensure the fields are as follows:

- Document type- soft copy
- Name- as is
- Description- fill in if you wish

You can then either select the file you want to upload

Or

Drag and drop it where it says" Drop file here'.

Click on 'OK'.

To add a reference to a hard copy document:
1. Click on "Add"

Ensure the fields are as follows:

- Document type- hardcopy
- Name- as is
- Description- fill in if you wish

Please use the following HREC templates when creating an information sheet and consent form: HREC templates

Documents attached to this application:

*

1	Document type	Soft copy
	Name	Information Sheet for Aged Care Leaders_Organisational_Content
	Reference (Document Title)	4.0 Information sheet Who do you say I am_Language and Culture_Organisational Artefacts-Documents.docx
	Description	Information Sheet_Organisational Content
2	Document type	Soft copy
	Name	Information Sheet Academics /Thought Leaders
	Reference (Document Title)	2.0 Information sheet Who do you say I am_Language and Culture_Academics.docx
	Description	Information Sheet
3	Document type	Soft copy
	Name	Informed Consent Form -Academics
	Reference (Document Title)	2.1 INFORMED CONSENT FORM Academics_20191231_Academics.docx
	Description	Informed Consent Sheet for International Academics /Thought Leaders
4	Document type	Soft copy
	Name	Informed Consent Sheet Aged Care Leaders
	Reference (Document Title)	INFORMED CONSENT FORM Providers_20191112_Aged Care Leaders.docx
	Description	Informed Consent Sheet for Aged Care Leaders
5	Document type	Soft copy
	Name	Information Sheet Artefacts -Documents
	Reference (Document Title)	4.0 Information sheet Who do you say I am_Language and Culture_Organisational Artefacts-Documents.docx
	Description	

6	Document type	Soft copy
	Name	Informed Consent-Artefacts_Documents
	Reference (Document Title)	4.1 Informed Consent Form_Artefacts_Documents.docx
	Description	Access to organisational documents for Content Analysis
7	Document type	Soft copy
	Name	Information Sheet_Site Visit
	Reference (Document Title)	3.0 Information sheet Who do you say I am_Language and Culture_Organisational Artefacts.docx
	Description	Site Visit infomation sheet
8	Document type	Soft copy
	Name	Consent Form for Site Visit
	Reference (Document Title)	3.1 INFORMED CONSENT FORM Providers__Aged Care_Site_Artefacts of Cultural Change.docx
	Description	This informed consent sheet is for Service managers at facility level who may need to be interviewed regarding items within the artefacts tool. A selected number of sites will be reviewed but this will only occur following interviews of C-suite leaders with their approval and support assisting in the service identification. A poster is also attached for broader information.
9	Document type	Soft copy
	Name	Questions for Thought Leaders and Academics
	Reference (Document Title)	2.2 Interviews with Academics thought leaders.docx
	Description	
10	Document type	Soft copy
	Name	Questions for Aged Care Leaders
	Reference (Document Title)	1.2 Interview Questions for Ethics_Aged Care Leaders.docx
	Description	
11	Document type	Soft copy
	Name	Artefacts of Cultural Change
	Reference (Document Title)	ArtifactsTool_Who do you say I am.doc
	Description	
12	Document type	Soft copy
	Name	Research questions and approach one pager
	Reference (Document Title)	Research A3 Approach and Methods_LJ.docx
	Description	This document is a table of the research questions associated with this doctorate which what methods and approaches will be utilised to answer the research aims and questions.
13	Document type	Soft copy
	Name	Poster for Site Visits
	Reference (Document Title)	3.3 Poster for site visits.docx
	Description	Poster for site notice boards regarding the observations. This is to inform all those-carers, residents, staff of what is occuring on the day the visit is being conducted.

Please read the submission instructions carefully at the end of this application form.
Please save and continue to the next page

Declaration

Declaration

I have answered all questions in the risk assessment truly and completely to the best of my knowledge

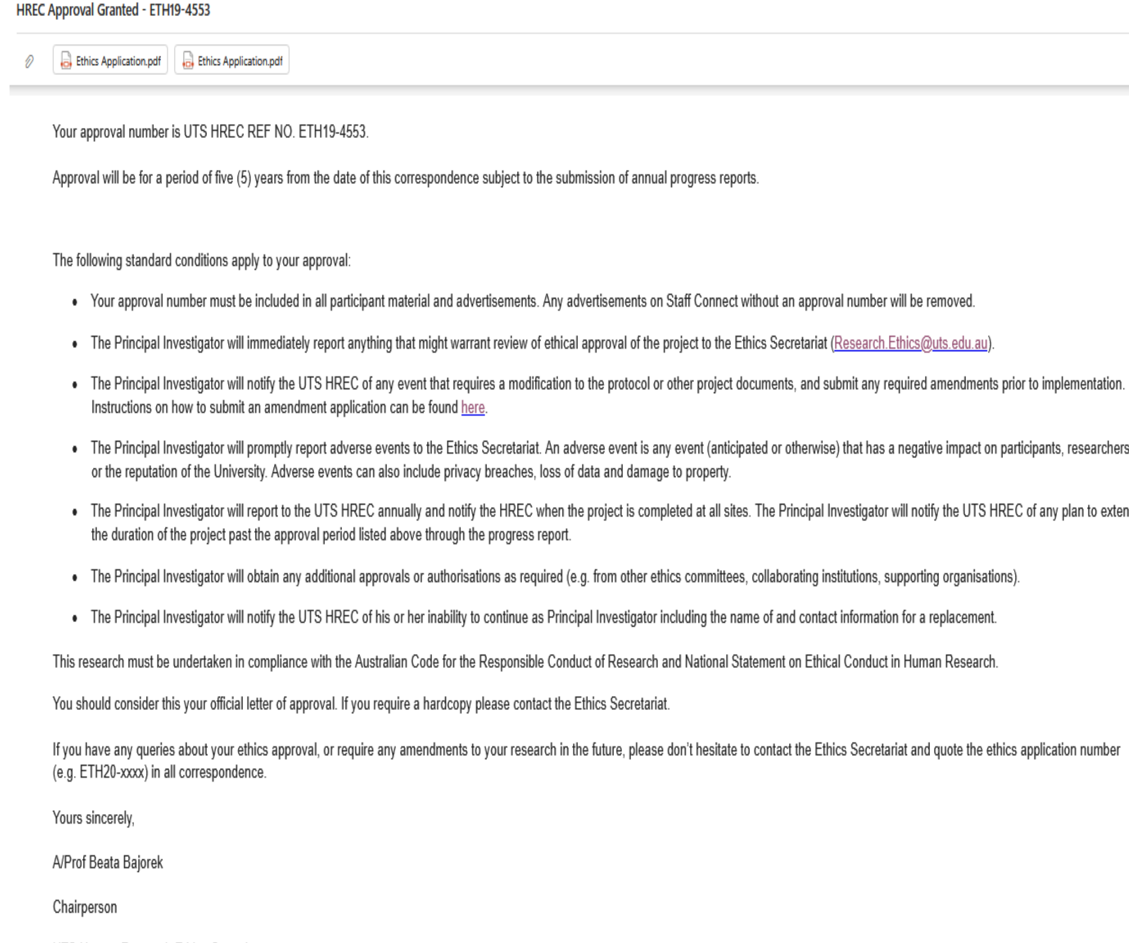
I will notify the UTS Human Research Ethics Committee of any variation to this research that may alter the level of risk associated with it

This research will be undertaken in compliance with the UTS Research Ethics and Integrity Policy or any replacement or amendment thereof

This research will be undertaken in compliance with the Australian Code for the Responsible Conduct of Research and National Statement on Ethical Conduct in Human Research

please click on the "Submit" button in the Actions menu.

10.2 Ethics Approval



HREC Approval Granted - ETH19-4553

Ethics Application.pdf   Ethics Application.pdf

Your approval number is UTS HREC REF NO. ETH19-4553.

Approval will be for a period of five (5) years from the date of this correspondence subject to the submission of annual progress reports.

The following standard conditions apply to your approval:

- Your approval number must be included in all participant material and advertisements. Any advertisements on Staff Connect without an approval number will be removed.
- The Principal Investigator will immediately report anything that might warrant review of ethical approval of the project to the Ethics Secretariat (Research.Ethics@uts.edu.au).
- The Principal Investigator will notify the UTS HREC of any event that requires a modification to the protocol or other project documents, and submit any required amendments prior to implementation. Instructions on how to submit an amendment application can be found here.
- The Principal Investigator will promptly report adverse events to the Ethics Secretariat. An adverse event is any event (anticipated or otherwise) that has a negative impact on participants, researchers or the reputation of the University. Adverse events can also include privacy breaches, loss of data and damage to property.
- The Principal Investigator will report to the UTS HREC annually and notify the HREC when the project is completed at all sites. The Principal Investigator will notify the UTS HREC of any plan to extend the duration of the project past the approval period listed above through the progress report.
- The Principal Investigator will obtain any additional approvals or authorisations as required (e.g. from other ethics committees, collaborating institutions, supporting organisations).
- The Principal Investigator will notify the UTS HREC of his or her inability to continue as Principal Investigator including the name of and contact information for a replacement.

This research must be undertaken in compliance with the Australian Code for the Responsible Conduct of Research and National Statement on Ethical Conduct in Human Research.

You should consider this your official letter of approval. If you require a hardcopy please contact the Ethics Secretariat.

If you have any queries about your ethics approval, or require any amendments to your research in the future, please don't hesitate to contact the Ethics Secretariat and quote the ethics application number (e.g. ETH20-xxxx) in all correspondence.

Yours sincerely,

A/Prof Beata Bajorek

Chairperson

UTS Human Research Ethics Committee

C/- Research Office University of Technology Sydney

E: Research.Ethics@uts.edu.au

10.3 Interview Question Protocols

Interview Guide: General Semi-structured interviews Aged Care Leaders

(information on this page are notes for the researcher as the interview commences)

Purpose of the study

(As per Information sheet originally sent)

Given your role. and the time you were at …….

Any particular opinions you have on the policy shifts and the impact of, or opportunities presented by the Aged Care Royal Commission on your transformation will be most helpful. The conversation will revolve around:

- What type of transformation you undertook, how did you plan and deliver these?
- What was the catalyst for change?
- Was there a model or approach you thought to implement?

The interview should take approx. 1 hour.

My hope would be that they will assist all providers and all social service sectors with factors to support transformation by enhancing quality and service provision to support the inherent dignity of each person regardless of age or disability.

Consent

Did you receive the document that describes the study attached to the email/letter? (show study information sheet)?

No – (review the sheet and explain the study in detail)

Yes, (briefly check if there are questions or points for clarification).

Can I ask you to sign this Consent form for the study now? Explain, it’s a standard consent it outlines that.

- You understand what the research will involve
- You are happy to be recorded
- You know that you can change your mind and withdraw and stop the interview at any point without providing a cause
- You name and role will be included in the final document
  Your personal information will remain private, your name will not be attributed to quotes is information in the final write up.

You consent to participate?

-

Interview #

Contextual Information

- Demographics M / F
- What is/was your role?
- How long were you in this role?
- Size of service/provider /multistate?
- For Purpose/ NFP/ For Profit?
- Specialist services- e.g. Dementia/ Palliative Care/ homelessness

Transformation and Approach

Model and approach

1. What does quality mean to you?
2. What Person Centred Care models were you aware of before you commenced?

a. Did you use an off the shelf model or design your own?

b. Did you modify the model for your context?

c. How would you describe your model of care before you started your transformation?

3. If you chose an off ‘the shelf’ model which model, did you choose, why?
4. When and how did you start your change journey?
5. Why did you start your journey, any trigger event?

a. How would you describe the language and tone associated with care delivery at the start?

b. What was and is the collective term you use for people residing in your services?
6. How extensive, approach- pilot or broad scale?
7. Were co-design principles with clients and staff included in the design?
8. How did you build capability?
a. Induction
b. Coaching at site level
c. Train the trainer -roll out
d. Online roll out?
9. Thinking of how and where the change programme was managed and delivered. Where within your organisation was the change programme delivered from? from Organisational development/ Special projects/Operations/ Customer Experience?
a. Did you change over the course of the change journey?
10. Was the transformation program branded?

Evaluation and Dissemination

1. How many years has the model been in practice?
a. How would you describe the language and tone associated with care delivery now?
b. Any particular aspect of the change to practice that stands out?
2. How did you capture any Lessons learnt and how were these shared?
3. How did you disseminate achievements within and external to your organisation?
4. How would you describe the language and tone of interaction between carers and clients now?
5. Have you evaluated your model implementation?
6. Who did the evaluation and how?

Governance, Risk Management

1. Were your board engaged in the development and approaches of the change programme?
2. How did you balance risk and the transformation?

a. Were there any regulatory issues as you progressed your implementations i.e. sanctions, not-mets over the course of the transformation?

b. Did the changing regulatory environment (ACRC) new Standards support or detract from your transformation approach? I.E. push you towards compliance or transformation?

3. How did you track success and progress?

Rationale for making the change

When you consider the transformation and changes you have implemented what are the main reasons for the change?

What was the rationale and what did you set out to achieve?

Possible probes:

- Deregulation
- Increased competition
- Profitability
- Alignment with Mission and Vision

What do person centred approaches mean to you personally?

Regulator and Government

Do you think the regulator has a role to pay in supporting the transformation?

Closing

Is there anything else you’d like to say or share that may not have been included in the questions thus far?

Anything else, questions for me?

Explain next steps and reiterate confidentiality and anonymity

10.4 Participant Information Sheets

INFORMED CONSENT FORM – PROVIDERS- Aged Care Leaders

Who do you say I am? Language, Culture and their intersection with safety and quality.

UTS HREC APPROVAL NUMBER ETH19-4553

I ____________________ agree to participate in this Study by Prof. Joanne Travaglia, Dr Deborah Debono and Doctoral Student Linda Justin, UTS HREC approval reference number ETH19-4553Level 11, Building 10, 235 Jones St, Ultimo NSW ph.: (02) 9514 5256.

The research project is being conducted to fulfil the requirements for Doctor of Philosophy, at University of Technology Sydney.

I understand that the purpose of this study is to better understand what makes a program or intervention successful to help improve the lives of people living in residential aged care. The study will involve speaking with, Board Members, Executives from Providers in Australia, to obtain their perspectives and ideas about what organisational enablers support the delivery of change programs to support people living in Residential Aged Care.

I understand that my participation in this research is as a person who is a Board Member or Executive of a service provider in the aged care sector, a member of a Board of an aged care service provider.

My participation in this research will involve a face-to-face interview for up to one hour. Interviews will be recorded and transcribed, and should pose minimal risks, threats or inconvenience.

I agree to be:

☐ audio recorded

I agree to keep confidential all information including all conversations and discussions or interview and any information provided to me by the UTS research team.

I agree that the research data gathered from this project may be published in a form that:

☐ Does not identify me in any way
☐ May be used for future research purposes

I am aware that I can contact Prof. Joanne Travaglia, Dr Deborah Debono or Ms Linda Justin, if I have any concerns about the research.

I understand that I am free to withdraw my participation from this research project at any time I wish, without consequences, and without giving a reason.

I agree that Ms Linda Justin, has answered all my questions fully and clearly.

____ ____/____/____

Name and Signature (participant) Date

____ ____/____/____

Name and Signature (researcher or delegate) Date

NOTE: This study has been approved by the University of Technology Sydney Human Research Ethics Committee (UTS HREC). If you have any concerns or complaints about any aspect of the conduct of this research, please contact the Ethics Secretariat on ph.: +61 2 9514 2478 or email: Research.Ethics@uts.edu.au and quote the UTS HREC reference number. Any matter raised will be treated confidentially, investigated and you will be informed of the outcome.

10.5 Literature Map

Literature Map (Cresswell, 2009)

Poor house to Nursing Home
Carboni, 1990, Sheldon, 1948 UK
History– Gibson, 1986, Jalland, 2015, Cullen, 2004, Kendig and Duckett, Robertson, 2021
Jilek, 2000

PCC as a Philosophy

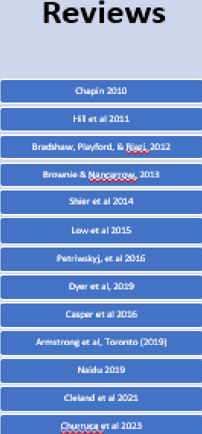
Culture Change Models and Movement

- Eden- Larkey, 2022
- SHM-
- My Home life- Meyer,
- Relationship Centred Care-
- Household
- Green House
- Pioneer Network
- Movement Lehning and Austin 2010, Kane, 2003, Eliopoulos, 2010, Koren 2010, Brune 2011, Miller, Miller et al, 2010,Brune 2011, Dupuis et al, 2016, Churruca et al 2023

Implementation

Reviews, Constituent parts, and Evaluations

Systematic Reviews



Quality of Life & Quality of Care

- Cooney, 2014
- Hughes & Moore 2012
- Shier, Khodyakov et al. 2014
- Miller et al 2014
- Bowers et al, 2016,
- Young and Rodgers, 2017
- Posy, 2017
- Palmer, et al 2018
- Dyer et al , 2018
- Milte et al 2019
- Wells et al, 2019
- Towers, 2019
- Naidu, 2019
- Cleland, Hutchinson, Khadla 2021
- Lepore et al, 2020

CDC
- Rodgers, et al 2012
- O'Dwyer, 2013
- Schnelle Rahman et al, 2013
- Edvardsson, Fetherston, Nay 2010
- Brush and Calkins, 2016
- McCabe 2022
- Naidu, 2019
- Milte et al, 2019

Language & Terms
- Bowman, Ronch, Madjaroff, 2010 (commissioned)
- Brown, 2017
- Wild and Kidd, 2016
- Hande 2021

Choice and Preferences
- Bangerter et al, 2016
- Bangerter et al, 2017

Definition of PCC
Anon AGS, 2016

Measurement of PCC
Van Haitsma et al, 2014

Practice aspects
Bathing, Radar
Wake time Harrison and Frampton, 2017

Space and Environment
Nordin, Mckee, Wijk, & Elf, 2017
Yoon, 2018
Carnemolla et al, 2019
Davila, Johnson and Sullivan, 2020

Leadership & Culture
- Tyler and Parker, 2011
- Eliopoulos, 2013
- Bird, Anderson, Macpherson & Balir, 2016
- Backman, Sjorgren, Lindkvist, Lovheim, & Edvardsson, 2017
- Batten, Thomas, Christensen, Lundin, 2017
- Levitt, 2018
- Naidu, 2019
- Churrucca et al, 2023

Dignity of Risk
Ibrahim et al, 2020

Consistent staffing
Roberts, Nolet and Bowers, 2015
Harrison and Frampton, 2017

Financial aspects
Occupancy
Revenue
- Grabowski
- Elliott

Dementia and Culture Change
- Venturo et al, 2013
- Brown-Wilson et al, 2013
- Willemse et al, 2015
- Bird et al, 2016
- Dupuis et al, 2016
- Chenoweth et al, 2019

Thriving
- Bjork, Lindkvist, Lovheim, Bergman, Wimo, & Edvardsson, 2018

10.6 Findings

10.6.1 Joint Display -Financing

Financing	**Phase 1** **Prominence Scores**					**Phase 2** **Themes**
Reports	**Care**	**Costs**	**Funding**	**Needs**	**Services**	Bureaucracy and control 6.5.3 Bureaucracy and funding 6.5.5 Tensions and Funding model 6.6.3 • 'I'm not the shower and I'm not the feed, you know, I'm not the dementia, you know, I'm Maisie or whoever I am' (Aged Care Executive 32)
2011 Caring for Older Australians	1.39	2.69	1.96	1.52	1.80	
2016 Aged care roadmap	1.74	1.34	2.60	3.89	1.68	
2017 Legislated review	1.64	1.73	1.47	1.67	1.61	
2017 Review of care quality regulation	1.23	0.04	0.47	0.82	0.67	
2021 Royal Commission-Neglect	1.21	0.22	0.90	1.01	1.00	

10.6.2 Joint Display Regulation

<table>
<tr><th rowspan="2">Regulatory Aspectss</th><th colspan="7">Phase 1
Prominence Scores</th><th>Phase 2
Themes</th></tr>
<tr><th>Accreditation</th><th>Complaints</th><th>Quality</th><th>Regulation</th><th>Regulatory</th><th>Risk</th><th>Standards</th><td rowspan="6">Bureaucracy and Regulatory framework 6.5.4

Tensions and the regulatory framework 6.6.2

• big stick approach’ (Aged Care Executive 35
• ‘Why do you need jack booting accreditors coming in with a hermeneutic of suspicion?’ (Aged Care Executive 45)
• ‘Absolutely heartless in their approach’ (Aged Care Executive 42
• ‘the way the regulator speaks’(Aged Care Executive 100)
• ‘the regulatory model where providers find themselves in a situation of being more afraid of the regulator is not one that drives quality’(Aged Care Executive 12)</td></tr>
<tr><td>2011 Caring for Older Australians</td><td>1.01</td><td>1.28</td><td>1.27</td><td>1.57</td><td>1.27</td><td>1.25</td><td>1.28</td></tr>
<tr><td>2016 Aged care roadmap</td><td>1.00</td><td>0.63</td><td>1.96</td><td>0.93</td><td>0.73</td><td>0.31</td><td>2.46</td></tr>
<tr><td>2017 Legislated Review</td><td>0.22</td><td>0.30</td><td>0.50</td><td>0.88</td><td>0.38</td><td>0.79</td><td>0.65</td></tr>
<tr><td>2017 Review of care quality regulation</td><td>6.07</td><td>5.17</td><td>3.64</td><td>3.57</td><td>5.14</td><td>2.86</td><td>4.29</td></tr>
<tr><td>2021 Royal Commission- Neglect</td><td>0.44</td><td>0.51</td><td>0.94</td><td>0.50</td><td>0.47</td><td>1.28</td><td>0.51</td></tr>
</table>

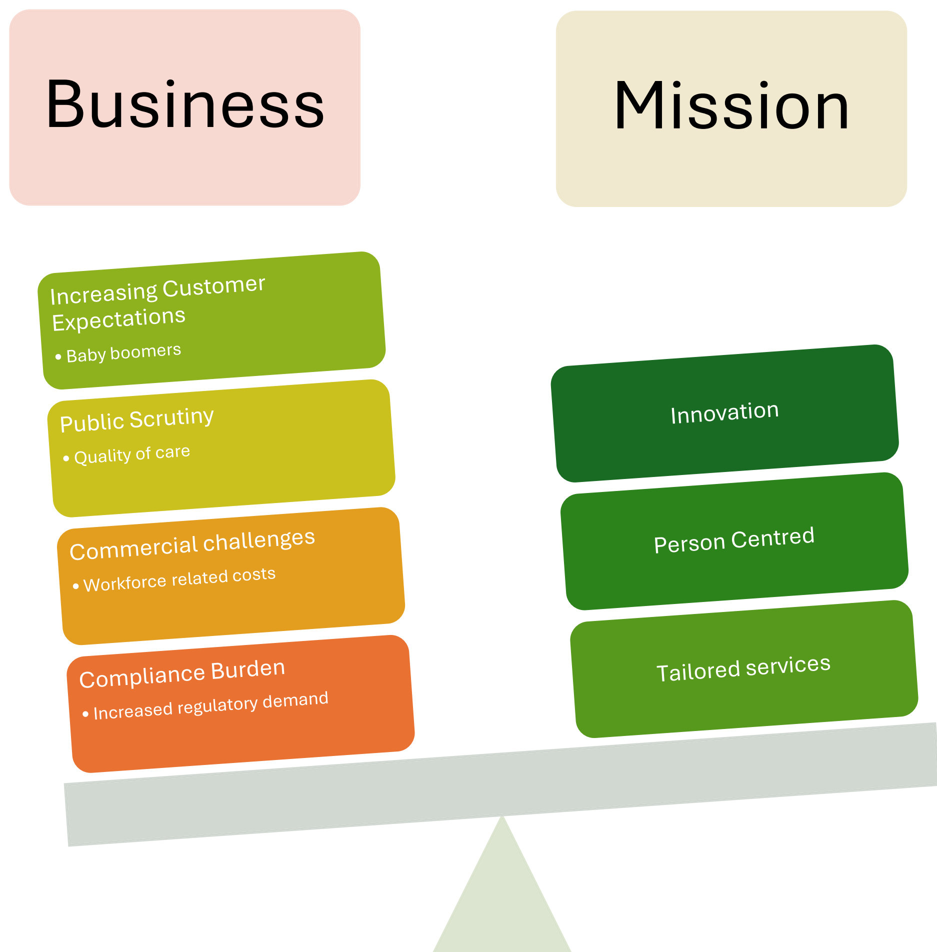
10.6.3 Joint Display -Department of Health and Act

Government and Department of Health	**Phase 1 Prominence Scores**							**Phase 2 Themes**
	Consumers	**Costs**	**Department Of Health**	**Funding**	**Government**	**Home**	**Needs**	Tensions and the Aged Care Act 6.6.1 • "It wasn't designed in the interests of the older person, the person receiving the care. It was designed to meet the needs of a regulator, and a funder, and providers who needed to tap into that system". (Australian Aged Care Executive 22)
2011 Caring for Older Australians	0.67	2.69	0.54	1.96	0.98	1.16	1.52	
2016 Aged care roadmap	5.89	1.34	0.00	2.60	3.60	1.41	3.89	
2017 Legislated review	3.75	1.73	2.93	1.47	4.09	2.96	1.67	
2017 Review of care quality regulation	2.00	0.04	2.34	0.47	0.76	0.51	0.82	
2021 Royal Commission-Neglect	0.11	0.22	1.11	0.90	0.31	1.04	1.01	

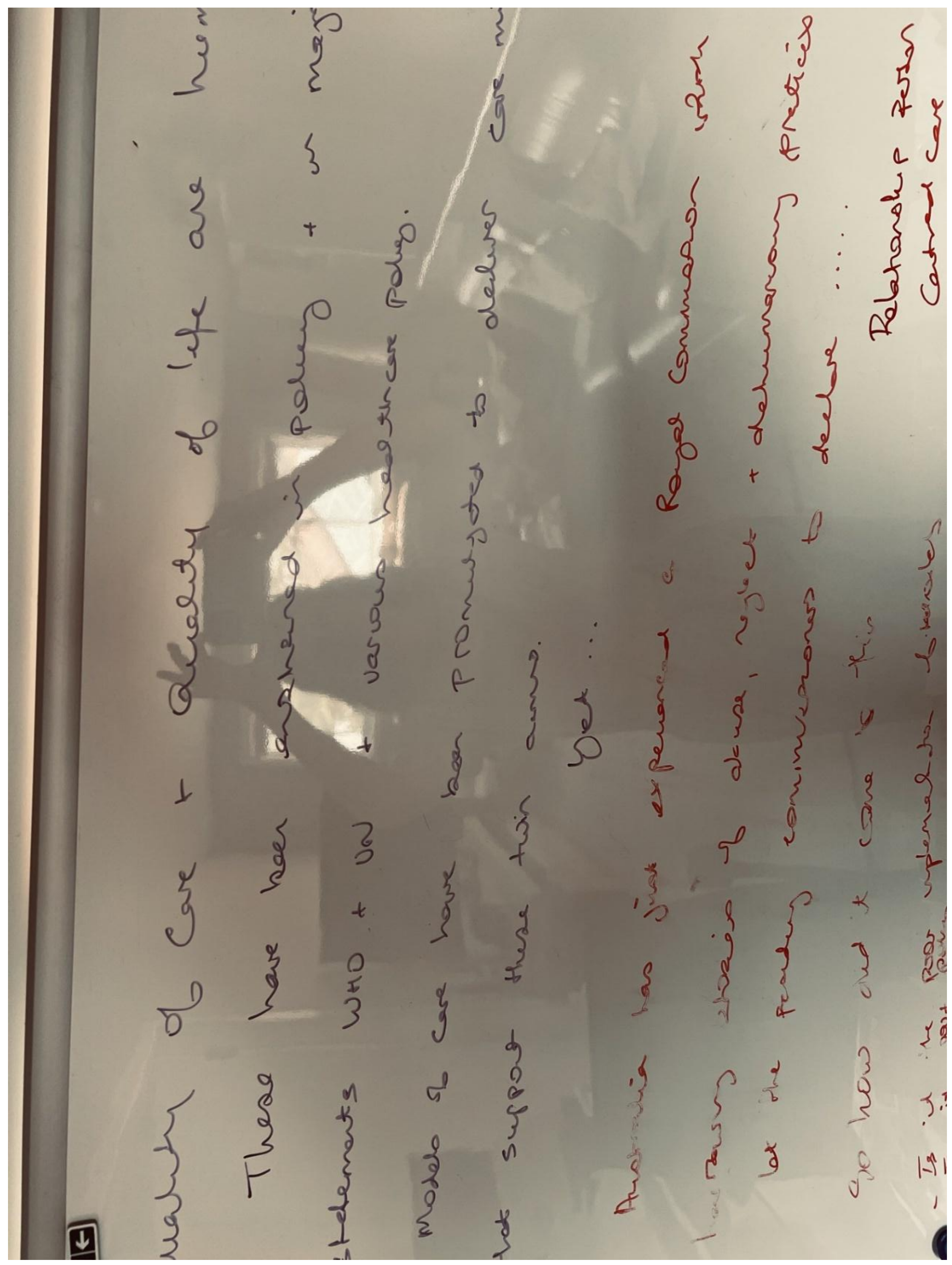
10.6.4 Joint Display- Terminology

Terms and aspects related to people and choice	**Phase 1 Prominence Scores**						**Phase 2 Themes**
	Consumer	**Life**	**Needs**	**People**	**Person**	**Residents**	Equivalence and Ambivalence in Care Terminology Section 6.5 Perspectives regarding the term Consumer Section 6.5.1 Tensions and the regulatory framework -safety vs personal choice 6.6.2 • "The word is now more frequently used in the sector, and we are seeing an increase in the view that people are consumers. However, this shift has occurred because the funding environment dictated it, and the external market has driven a lot of that change. This has been a shift for providers and staff that have traditionally worked in a closed traditional social community model" (Aged Care Executive 37) • 'I'm not the shower and I'm not the feed, you know, I'm not the dementia, you know, I'm Maisie or whoever I am' (Aged Care Executive 32)
2011 Caring for Older Australians	0.67	1.19	1.52	1.17	1.31	1.23	
2016 Aged care roadmap	5.89	1.15	3.89	1.02	0.20	0.47	
2017 Legislated review	3.75	0.23	1.67	1.15	0.85	2.08	
2017 Review of care quality regulation	2.00	1.60	0.82	0.43	0.43	2.28	
2021 Royal Commission- Neglect	0.11	2.12	1.01	2.14	2.22	0.80	

10.7 Reflexive Thinking and Journey



10.7.1 Figure 10.7.1 Brainstorm 2019



10.7.2 Figure 10.7.2 Brainstorm 2024

10.7.3 Figure 10.7.3 January 2025