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Routine Quality-of-Life Measurement in Residential Aged Care: Staff, Resident, and Family Perspectives

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Abstract

Background and objectives There is interest in routinely measuring quality of life (QoL) in aged care homes, evidenced by the Australian Government's implementation of QoL as a mandatory quality indicator. This study explores views of aged care staff, residents, and family members on the benefits, challenges, and feasibility of implementing routine QoL measures.

Methods Qualitative data were gathered to explore staff, resident, and family perspectives on QoL measurement in aged care homes, including purpose, benefits, implementation, and best practice. Two staff workshops were conducted at different aged care homes, and semi-structured interviews were held with 29 proxies (9 family members and 20 staff) and 24 residents. Workshops and interviews were transcribed verbatim, and thematically analysed via a qualitative interpretive approach using NVivo software.

Results Analysis yielded four key themes: (1) benefits of routine QoL measurement; (2) challenges in implementation; (3) best practice for collecting surveys; (4) validity concerns. Identified benefits included potentially improved care, monitoring service performance, and informing family members. Staff participants recommended integrating measures into existing care planning and having oversight from a registered nurse. Participants identified potential implementation challenges, including administrative burden, time and resourcing constraints, conflicts of interest, and resistance from staff, providers, and residents.

Conclusions This study identifies potential benefits to implementing routine QoL measurement in residential aged care homes. To maximise these benefits, it is important to consider how measurement can be integrated in ways that contribute to existing care planning and practices.

Key Points for Decision Makers

Routine quality-of-life measurement in aged care homes has the potential to help provide person-centred care by identifying residents' needs and improving care planning.

Implementing routine quality-of-life measurement in aged care homes may potentially increase the administrative burden on staff and residents.

Aged care staff argued that integrating quality-of-life measurement into existing care plan evaluations would make the benefits more impactful.

1 Introduction

Quality-of-life (QoL) tools, as types of patient-reported outcome measures (PROMs), generally aim to understand how physical health, disability, mental health, social relations, environment, and other factors affect an individual's functioning and perceived physical, emotional, and social well-being [1, 2]. However, there is ambiguity about the definition of QoL as a concept. Diverse tools operationalise QoL differently, prompting experts to advocate for clear explanations of and justifications for applying QoL tools to specific research and practice questions [3, 4].

QoL is routinely measured, in various ways, within many healthcare contexts, in order to measure the effectiveness of treatments or compare the performance of providers

Extended author information available on the last page of the article

[5, 6]. However, routine QoL measurement has been less common in aged care¹ settings [2]. This is partly due to the unsuitability of many available instruments, which operationalise QoL in relation to physical health and specific diseases [7, 8], may have questionable validity in aged care settings [9–11], or are not adapted for older people [12]. Existing measures of health-related quality of life (HRQoL) are typically designed to measure improvements in health that arise from treatment, while in an aged care context, it is more appropriate to measure the maintenance of QoL in relation to a range of factors [13].

There is interest in implementing routine QoL measurement for residential aged care residents due to a range of potential benefits [14–16], including better recognition of residents' individual needs, improved care planning, and a person-centred approach to quality assessment and service improvement. Additionally, QoL measurement may be linked to other quality measures or residents' satisfaction ratings and testimonials to measure provider performance [17].

There is an existing literature investigating implementation of QoL instruments in clinical settings [18], but relatively few studies of their implementation into aged care. A Canadian study by Hoben et al. [14] has shown 'proof of concept' for using the DEMQOL-CH instrument to measure QoL among cognitively impaired nursing home and assisted living residents, and provides some indication of the resources required for adoption. The study found good inter-rater reliability (intracluster correlation = 0.735) and high internal consistency (Cronbach's α = 0.834) when nurses and other care staff used the tool, as well as good ratings of acceptability, feasibility, and validity among staff. However, the study is limited insofar as the DEMQOL-CH is a proxy instrument rather than self-reported by residents and the study population only included residents with cognitive impairments.

Broadly speaking, implementation of QoL measurements in aged care homes has been limited. This has been attributed to the perceived complexity and resource-intensiveness of QoL instruments [19] and perceptions that staff and providers have limited scope to improve practices [16]. The aged care sector is a complex and changing context, with distinct factors affecting the success of new innovations such as QoL measurement [20, 21]. In aged care homes, the adoption of new innovations is typically driven by organisational decisions or government regulation changes, compared with healthcare settings,

where clinicians may have greater autonomy over how they assess and treat individual patients [22]. Relationships between care providers and recipients also differ, with aged care involving long term, high frequency, and routine-based care relationships, and healthcare typically being short-term and/or episodic [20]. Moreover, the aged care workforce has a distinct composition of roles and skills and the fact that most face-to-face care tasks are not performed by clinically trained and accredited personnel creates challenges when implementing innovations developed for healthcare settings.

Despite these challenges, a recent update to Australian regulation now mandates the regular measurement of QoL in aged care homes. The *National Aged Care Mandatory Quality Indicator Program* (QI Program) requires all government-subsidised residential aged care services to collect and report quality indicator data to the Department of Health and Aged Care on a quarterly basis. In April 2023, the program was expanded to include QoL as one of its 11 quality indicators [23, 24]. This program employs the *Quality of Life Aged Care Consumers* (QOL-ACC) tool, a preference-weighted measure specifically designed for older adults receiving aged care services, emphasising person-centred care [25]. Therefore, examining the routine measurement of QoL in aged care is both timely and essential.

2 Aim and Methods

This is a qualitative study that aimed to investigate the perspectives of aged care staff, residents, and residents' family members on the routine collection of QoL data in residential aged care homes in relation to its benefits, feasibility, validity, and implementation. The study is based on group discussions with staff and family members, and individual interviews with residents and proxies (i.e., aged care staff or family members), conducted prior to the addition of QOL-ACC to the QI Program. This is part of a broader project examining the face validity and implementation of a range of QoL instruments in residential aged care. The overall project comprised five steps: (i) interviews with residents to explore the face validity of four QoL measures and residents' views towards QoL data collection [10]; (ii) interviews with aged care staff and relatives to examine the feasibility of proxy reporting residents' QoL and their perceptions towards QoL data collection [11]; (iii) workshops with aged care staff and relatives to design the process for routine QoL data collection; (iv) piloting the QoL data collection process; and (v) interviews with aged care staff to reflect and evaluate the data collection process. This paper utilises data collected from steps 1–3 of the project, which focuses on the perspectives of aged care staff, residents, and residents' family members on the routine collection of QoL data in residential aged care homes. The study was approved by the Monash

¹ The term 'aged care' here reflects usage in Australian Government legislation (Aged Care Act 1997), which is defined as personal care or nursing care specifically for older people (aged 65+ years), delivered in a residential facility or in the person's home. This study focuses exclusively on residential facilities.

University Human Research Ethics Committee (Project ID: 32170). All participants provided informed written consent prior to participating in this research.

2.1 Workshop Recruitment and Procedure

Group discussions were conducted during two workshops with aged care staff members, family members, and members of the research team. Two workshops took place at two not-for-profit residential aged care homes in Melbourne, Australia in October and December 2022, respectively. Participants were recruited through convenience sampling. Staff and family members were sent invitation emails (from the facility manager) and information sessions were held during staff and family meetings at the two facilities. Those who were interested were asked to contact the research team to express their willingness to participate in a workshop. Each workshop was limited to 10 participants to maintain an interactive environment, promote individual contributions, and ensure effective facilitation of group discussions. On the day of the workshop, all participants provided written consent and received a gift card (A\$80) for their participation in the workshop.

The workshop was scheduled for 90 minutes and was structured around five topics, which were based on the ISO-QOL (International Society for Quality of Life Research) *User Guide for Implementing Patient-Reported Outcomes Assessment in Clinical Practice* [26]: (i) Purpose/benefits of QoL assessment; (ii) Selecting residents for assessment; (iii) Who should collect QoL data? (iv) When should QoL be assessed? Selecting timing for assessment; and (v) Other data collection considerations. The workshop and interview question guides were developed by LE and FB and piloted with other members of the research team. They are included as electronic supplementary material (ESM).

At the start of the workshop, an animated video was shown to workshop participants that summarised the aims and steps of the research project. The workshop was facilitated by an experienced qualitative researcher (FB), with two additional researchers present to provide assistance and take notes. The workshop was audio recorded and transcribed verbatim afterwards.

2.2 Interview Recruitment and Procedure

Proxies (family members and aged care staff) were recruited between September and November 2022 across three not-for-profit residential aged care facilities, which include the two workshop sites. Recruitment strategies included posting flyers in the aged care facilities, direct email invitations sent by the facility manager, and holding information sessions at the respective facilities. Individuals interested in participating contacted the research team to obtain further information

and schedule an interview, which took place at the facility or online (via Zoom). Family proxies could participate regardless of the resident's involvement and were not restricted to proxies of residents with cognitive impairments. All interviews (scheduled for 60 minutes) were audio recorded, and a gift voucher (A\$30) was provided to all participants after the interview. The primary aim of the proxy interviews was to explore proxies' views towards the appropriateness of a recently developed QoL instrument, the EQ-HWB, in measuring residents' QoL [11]. Part two of the interview examined proxies' views towards the routine collection of QoL data in residential aged care, which was used for the present study.

Interviews with residents were approximately 30 min in length and took place between October and November 2022 across the same three residential aged care facilities. Each facility nominated residents for the interview based on cognitive functioning and their ability to speak and understand the English language. The cognitive functioning of residents was determined using their most recent Psychogeriatric Assessment Scale—Cognitive (PAS-Cog) score, with the respective facilities assessing each resident's ability to participate in the interviews. The research staff then provided an information sheet to each resident and discussed the study. Residents who agreed to participate provided written consent prior to the interview. While the primary aim was to explore residents' views and understanding of four QoL measures, part two of the interview assessed their views towards the routine collection of QoL data in residential aged care, which was used for the present study.

A previous review suggested that data saturation—defined as the point at which no new themes emerge from additional data collection—is typically achieved after 9–17 interviews with homogenous study populations [27]. Based on this, we estimated a sample size of approximately 20–30 participants to ensure we captured the perspectives of both proxies and residents. Data saturation was assessed through discussions between the two interviewers following each interview, during which they evaluated the level of repetition and the emergence of new information. As stated above, these study data were collected as a part of a broader research project. Data saturation was assessed with the project's aims and objectives in mind rather than the thematic analysis undertaken for this paper.

The workshops and interviews were all audio recorded and transcribed verbatim. Transcripts were not returned to participants for checking.

2.3 Analysis

Our analysis was informed by a qualitative interpretive framework, which focuses on understanding participants' experiences and perceptions to address the study's aim of

understanding the perspectives of aged care staff, residents, and residents' family members on the routine collection of QoL data in residential aged care homes, focusing on its perceived benefits, feasibility, validity, and practical implementation. Thematic analysis was employed as it aligns with this framework [28], allowing for the identification and interpretation of key patterns and themes within the data. Our approach blends deductive (the *a priori* nomination of parent codes) and inductive elements (in-vivo development of child codes). To maintain consistency and ensure a comprehensive analysis, all qualitative data were analysed collectively after the completion of data collection. This approach allowed for a cohesive interpretation of the data in relation to the study's objectives.

The analysis proceeded as follows. Transcripts were imported into NVivo 1.7.2 (QSR International) by two members of the research team with experience in qualitative coding (LE and AG), using the following procedure. After initially reading the transcripts, the coders met to discuss the aims of the study and objectives of the analysis. They then separately coded the transcripts in NVivo, by starting with five mutually agreed parent codes: 'benefits', 'barriers', 'validity of data', and 'collection and reporting process'. More specific child codes were independently developed in-vivo. The coders met several times during the coding process to discuss progress, the coding strategy, and potential themes. A common framework of parent and child codes (included as ESM) was consolidated through discussion after approximately half of the transcripts had been coded. Once initial coding was completed, the two coders each independently reviewed the transcripts again and developed a list of key themes and selected representative quotations. The coders merged key themes into a common set through discussion. AG then wrote definitions for the key themes, which were reviewed by LE.

3 Results

Participants of workshop one included three family members and three aged care staff members who were all lifestyle coordinators² or assistants. Workshop two comprised one family member and five aged care staff (two personal care workers, one nurse, one manager, and one lifestyle coordinator). In total, 29 proxies (9 family members and 20 staff members) and 24 residents participated in

Table 1 Characteristics of study participants participating in the interviews

Characteristic	
Residents	
	N = 24
Gender, female: n (%)	15 (63)
Mean age [SD], min–max	82 [8.6], 68–95
Country of birth, Australia: n (%)	16 (67)
English first language, yes: n (%)	22 (92)
Education: n (%)	
Year 10 or less	10 (42)
Year 11/12	3 (13)
Certificate	3 (13)
Diploma	2 (8)
University degree	6 (25)
Living in residential aged care: n (%)	
Less than half a year	3 (13)
Half to 1 year	6 (25)
1–2 years	3 (13)
3–4 years	6 (25)
6–10 years	3 (13)
More than 10 years	2 (8)
Unsure	1 (4)
Family members	
	N = 9
Gender	
Male	3 (33)
Female	6 (67)
Mean age [SD]	63 [17]
English first language	9 (100)
Relationship to resident	
Daughter/son	5 (56)
Partner	2 (22)
Sister	2 (22)
Frequency of visits	
Daily	2 (22)
At least once a week	5 (56)
Most days of the week	1 (11)
A handful times	1 (11)
Frequency of phone calls	
Never	4 (44)
Daily	2 (22)
At least once or twice a week	1 (11)
Most days of the week	2 (22)
Aged care staff	
	N = 20
Gender	
Male	3 (15)
Female	17 (85)
Mean age [SD]	44 [12]
English first language	10 (50)
Job description	
Lifestyle coordinator	6 (30)
Nurse	4 (20)
Personal care worker	8 (40)

² A lifestyle coordinator is typically a non-clinical leadership position in Australian aged care homes. Lifestyle coordinators maintain residents' quality of life by planning and organising recreational activities, events, and outings.

Table 1 (continued)

Characteristic	
Manager	1 (5)
Other	1 (5)
Nature of position	
Permanent/ full-time	7 (35)
Part-time	12 (60)
Casual	1 (5)
Employment duration	
Between 1–6 months	3 (15)
1–2 years	5 (25)
2 years and above	12 (60)

the interviews. Further characteristics of interviewed participants are presented in Table 1.

The analysis yielded four key themes: (1) benefits of routine QoL measurement, (2) challenges to implementation, (3) best practice for collecting surveys, (4) validity concerns. Each of these themes are described under the following sub-headings. Quotations have been selected to best illustrate the themes, rather than to represent every participant.

3.1 Benefits of Routine QoL Measurement

When workshop participants were asked about possible benefits of routine QoL measurement, attendees said they already had mechanisms to understand residents' needs and QoL through individual care plan evaluations. However, as participants explained, the QoL aspects of this assessment were not based on a formal instrument. One discussed benefit to formal routine QoL measures was that outcomes could be consistently recorded and reported upward to management or government in a standardised way, which might prompt positive change. Yet some participants argued that if mechanisms were not in place for this, there would be little benefit to formal routine QoL measurement over existing practices:

If this doesn't go somewhere where it's going to make a difference, there's no point doing it because we're already doing this to a level within the care plan evaluations and all their entry admissions." [Workshop 1, Staff member]

Workshop participants also agreed that QoL measures could be used by staff to identify areas for practice improvement. Individual staff may not have the skills or resources to identify issues such as depression or social isolation. However, a routine QoL measurement may make these issues more visible and prompt new strategies, such as mental health support.

So, if we're assessing quality of life of our residents, if there's improvements, we can practically do... For instance, through COVID we found that there was a lot of depression amongst the residents. So, because of that, we've been in touch with an organisation [anonymised] and they come in and do assessments for our residents for depression specifically. [...] So that's something we identified because of those assessments and that's an improvement to the quality of life that one-on-one we might as carers not have. [Workshop 2, Staff member]

Another benefit identified by workshop participants was that families may find QoL outcomes reassuring, which may reduce some of the 'guilt' [Workshop 1] associated with having a family member residing in aged care.

Because you can never have too much information about the person you love. There's no such thing as too much information. So, every bit of information you get, I think is just a bonus. [Workshop 1, Family member]

The family members interviewed echoed these sentiments, and recognised benefits in terms of prompting quality improvement and providing families with information. Family members also saw the benefits of taking consistent measures to report upwards, to the management of facilities or to the regulator.

That gives an idea of where the person is at. It's a matter of how then [facility name] might use this as feedback that they can then utilise in a way that will enhance their programs and does it provide that. [Proxy 3]

I think it's a good thing and whoever makes the rules for the standards of care in aged care should see this, definitely. [...] Possibly the manager of the aged care facility. They have a big job. [Proxy 2]

Residents who were interviewed also saw routine measurement as a potentially beneficial regulatory tool, which could inform government and potential consumers about the performance of facilities.

I'd probably give it to the government and see if they could help out aged care a little bit more. Although the government now is doing a pretty good job; they are looking after the aged care a little bit more than the last government. [Resident 24]

I think the family and residents should be able to say, "Well, that's not bad. They're looking after this, this and this". But it should be there available for people to see and regulated and checked every 12 months. [Resident 20]

Overall, there was optimism among many participants that routine QoL measurement could both raise expectations regarding the quality of residential aged care and provide a means to identify areas for improvement on both an individual and facility level.

3.2 Challenges to Implementation

The interviews and workshops included questions about potential challenges or barriers to implementing routine QoL measures. Workshop participants responded that there may be resistance from the sector.

I hate to say it, but you're going to have a lot of resistance. [...] With a lot of companies, ignorance is bliss. Why would they want to know this? They're not going to advertise that we want to know if someone's unhappy. [Workshop 1, Staff member]

Workshop participants said that many aged care providers would rather not measure anything that could reflect negatively on their business. Consequently, they expressed that routine QoL measurement would only be implemented across the sector through a mandate from the government regulator.

Yeah, but I think if you were mandating it that would be the only way it would work, that it becomes part of the normal process. [Workshop 1, Staff member]

Another possible source of resistance raised by workshop participants was staff. Participants claimed that many nurses would be sceptical about the benefits of routine QoL measurement, perceiving it as an administrative burden that takes time away from directly supporting residents.

Working in aged care for the last few years myself, I've watched survey after survey, company after company come and do things like this but nothing's changed. [Workshop 1, Staff member]

Workshop participants also said it would be challenging to allocate sufficient time and resources to QoL measurement, given the financial priorities of providers and the underfunding of the sector by government. Participants were concerned that if staff are not provided with time and resources to administer a QoL instrument properly, they will approach it in a task-oriented way and not sufficiently engage with residents to get their perspectives.

It'll be like you've been assigned a toolbox. So, you go in there and you'd read the first page and you're like, "Oh yeah, cool. Tick me off the thing". I don't know what it said, I didn't read it, I haven't got time, it's seven in the morning, I've got to go and do showers. [Workshop 1, Staff member]

Some family members and residents raised similar concerns about introducing surveys into an environment where staff are time poor and under-resourced.

I think the challenge is that they'd [staff] have the capability but may not have the capacity, just given the pressures in that environment. So, there might need to be extra remuneration of like, here's a four-hour block to do this survey with one resident or something. [Family Proxy 1]

*They do long, hard shifts, changing people's nappies, getting beaten up by the bloke next door who has got all sorts of anger issues. He's huge. They don't want to fill this s**t in, unless they're getting paid for it. They won't have time to do this unless time is allocated and that means somebody else on the floor has to do a shift. That's going to be a problem there. [Resident 5]*

Some residents were sceptical that QoL measurement could change anything and said they felt burdened by the number of surveys, appointments, and forms that residents were required to do.

It can't change that much, can it? So, if you do this it'll be the same if you come back in a year, just different people. It's the same institutions that are run the same way. [Resident 17]

I told the girl this morning, I don't feel like doing any interviews because I've got so many people coming in and asking me these questions. I said I've been flooded with people from the NDIS [National Disability Insurance Scheme] asking me questions all day, all the time. I've had it up to here with asking questions and filling surveys out. [Resident 24]

A few residents indicated they may decline if asked to complete a QoL survey and were not convinced it would be beneficial to them.

Because we get too many surveys to do. I've forbidden them to come in my door. [...] Old people don't want to be filling out surveys, they really don't. [...] What are statistics going to do for us? [Resident 9]

3.3 Best Practice for Collecting Surveys

When workshop participants discussed how QoL measures should be collected, most agreed that collection should be integrated into each residents' care plan evaluation to ensure greatest impact. QoL outcomes would accompany other information about the residents' health, biography, family situation, likes and dislikes, as well as other clinical assessments. This would allow the QoL outcomes to better influence the care planning process.

Well, I think it should be done when you do your care plan evaluation. [...] We do them every three-monthly. So perhaps you would incorporate that in the six-monthly. [...] It'll have, like I said, the physio, clinical, the dietitian, whatever specialists are involved in their care at the time, everyone is present and we're all bouncing off each other and bantering with the resident amongst them. And the resident gets the opportunity to speak and also their family is there as well so you could nail everybody at once. [Workshop 1, Staff member]

Care plans also contain information about residents that can be useful in conducting the survey. For instance, the care plan can help determine whether the resident would need to complete a survey verbally due to vision impairment, or whether using a proxy is appropriate due to cognitive impairment.

So, we have care plans for each resident, every resident in the facility and those care plans will identify things like cognitive impairment, are they verbal or non-verbal. So, every resident's got a standard care plan so all of that information is available to everyone. [Workshop 2, Staff member]

Workshop participants suggested that Registered Nurses (RN) are best placed to organise QoL measurement. The RN's role is to have a holistic picture of residents' needs, and to integrate information from various assessments, clinical information, and input from the resident and their family. Moreover, if RNs are responsible for ensuring QoL measures are completed, then they are more likely to conduct them properly and utilise them effectively. RNs are also accustomed to administrative tasks, including survey assessments, and therefore would require minimal training.

Carers overlook the care of the residents, ADLs [Activities of Daily Living], make sure they've got something to eat, they're eating well etc, etc. We've got Lifestyle [Lifestyle Coordinators] and they overlook the activities of the resident. We've got ENs [Enrolled Nurses]. They look over medication and wound care. The overall care of the resident is the RN. So, the RN does what the lifestyle are doing, the PCW [Personal care workers] are doing and the EN's doing. So, if you want to know about the resident you'd go to the RN because the RN has an oversight of the resident holistically, if that makes sense. Carers are more time poor than your Registered Nurse. [Workshop 2, Staff member]
And if you've got a lifestyle or PCW doing the interview if the resident being interviewed says, "I haven't been sleeping too well because I've got backpain" you then hope that that's translated to the RN. But if it doesn't, nothing happens. Whereas the RN in the

middle of that interview knows that I need to manage pain at the end of this interview because they've already flagged that there's a clinical issue they need to address. [Workshop 2, Staff member]

If QoL measurement is left to staff to administer during routine care, rather than by an RN during care planning, it is more prone to being interrupted by competing priorities.

Well, a different perspective is there's a carer in an apartment. If that carer is having to do this survey and sit out with that person, but there could be two other people in the apartment that are having a crap day. [...] And the carer has to administer some drugs, she can't ask a question. Set up the whole scenario, ask one question, and then a buzzer goes off and the carer has to then leave that situation. [Workshop 1, Staff member]

When asked how frequently QoL should be measured, there were a range of responses from staff, residents, and proxies. However, the most common response across all participant groups was six monthly.

I'd have thought six-monthly just to have some perspective about it. As we've mentioned, there are the short-term ones that pass [away], but I think in this reporting, to know how things are travelling over that longer period of six months rather than three months or monthly – for example, but I'd have thought six months was a reasonable time. [Proxy 3]

Probably twice a year or quarterly. I don't know, I think twice a year would be enough, because that gives six months for anything to kick in. [Resident 19]

Participants also broadly agreed that QoL surveys should be conducted in a private space, with a relaxed atmosphere. Ideally, this should be in residents' rooms and preferably administered by a member of staff who shares good rapport with the resident.

Yeah, just so long as you've got some sort of rapport with the residents, you should be okay. But if say I've got some random person just rocking up with all these questions, they're going to feel a little bit more intimidated. [Workshop 1, Staff member]

Because some understand you better, I think, than others. I have a different relationship with some people, some of the staff, for instance. [Resident 2]

So if it was one of the care staff, picking someone that she has a good relationship with that also has the time and is reimbursed to do that as well because that's a challenge. [Family Proxy 1]

Workshop participants were asked about the best time of day to administer QoL surveys, and responses varied from late morning to early afternoon. Various factors were mentioned, including how busy staff are, residents' preferences and fluctuating capacities, and timetable conflicts with other activities and family visits.

I mean just after lunch some of my residents, you're not going to get answers out. Some of them, all day, you're not going to get answers out of. Some of them, as soon as it hits afternoon, "This is not for me". They're not going to get all of that done. [Workshop 1, Staff member]

You could do it; you could have a schedule, but you would have to check on that day. It would have to be flexible. [Workshop 1, Staff member]

Overall, it was agreed that surveys needed to be administered flexibly according to the needs and preferences of individual residents, as well as staff schedules. Planning should consider that residents may be more capable of completing surveys at some times more than others, on some days more than others, and that residents have diverse and fluctuating capabilities.

3.4 Validity Concerns

Workshop participants raised some validity concerns that suggest important considerations for implementation. For instance, if staff are time poor and focused on task completion, workshop participants said there is a temptation to "tick boxes" to get things done. Consequently, workshop participants recommended making it very clear to staff that QoL measures require resident responses, not staff responses.

I also think you're going to have to, not so much train, but remind the staff in a way that not to just put their professional opinion on the form. Because we can all sit down and fill out a form for Resident A, B and C and give you our opinion, but we have to remember that you're [not] wanting the answer from us but from the resident. Don't put words in their mouth. [Workshop 1, Staff member]

Workshop participants suggested that staff or providers may be concerned that QoL measures could reflect badly on them, creating incentives to manipulate data. They claimed that RNs are less incentivised to distort information because they have less of a role in direct care.

If I'm going to be penalised as an organisation for providing negative feedback, then I'm going to be inclined to falsify the information I give you. [Workshop 2, Staff member]

I was going to say they would answer every question pretty much for their residents because they want everything to seem perfect. [Workshop 1, Staff member]

Similarly, workshop participants were concerned that surveys may be biased by residents' reluctance to disclose their experiences. This may be because residents do not want to cause problems, or they may be distrustful of staff and fear repercussions for providing negative responses.

One of their behaviours is suspiciousness, "Are you going to increase my meds with the wrong answer?" "Are you going to put me in a hole because I give you the wrong answer?" This is where their brain goes. [Workshop 1, Staff member]

Some family members and residents echoed these concerns.

I don't want it used here; they'll kick me out and I'll have to live on the street. I had to leave with three bags of clothes, that's how bad it got for me. You got me on a good day today, I don't feel down. [Resident 16] As a resident [i.e. imagining a resident's perspective], I've got to remember that if I try and complain too much, something might happen. [Family Proxy 9] I think she [participant's mother] might want to give the right answer as opposed to the correct answer, what she really thinks. So the one that jumped out for me was number five, washing. Like she hates that, she hates being washed by other people. But if the person interviewing her is the person who washes her and she likes that person, "Ah yeah, it's all fine. It's all fine, love". [Family Proxy 1]

Participants were asked whether it was appropriate for proxies to complete surveys when residents lack capacity. Residents said family member proxies may be appropriate, depending on the frequency of visitation and how engaged they are with the residents' circumstances.

He [resident's son] wouldn't know the answers to half of them. [...] No, because he doesn't experience [it] and I don't tell him. [Resident 2]

Because how often do the families come to visit? Some people will get a family member every day, others get none. Others might get one a month. I know one lady; she gets one a year. [Resident 9]

Workshop participants said that while family members are the most appropriate proxies, they would likely rate QoL of residents lower than staff or residents would.

Definitely family members are going to rate it lower. Yeah, because families have an expectation of what they think their family member should be doing, not realising the capabilities of their family member has

declined. And they've got that emotional attachment, whereas we've [staff] got the professional side. [Workshop 1, Staff member]

Family members also acknowledged that if they were acting as proxies, they may be motivated to influence survey outcomes to prompt changes in practice.

Well, if I answered those questions three weeks ago, it would have been all bad, bad, bad. That was because of her physical condition. Even then, I think the care that she was getting here, but that's not what it's about. [Family Proxy 8]

When discussing residents' capabilities to complete surveys themselves, workshop participants said approximately half could do so with adequate support. Other residents could be 'assessed' by staff.

So are we asking residents or are we assessing residents? Because if we're asking residents, then I'd do half of them but if we're assessing residents then everyone should be assessed. [...] If you think about more generally, if they can't communicate or cognition wise, we assist them every day, we monitor them every day, their changes. From that perspective, we can answer those questions. [Workshop 2, Staff member]

To support residents doing surveys independently, QoL instruments should be brief, and the wording should be simple.

A lot of the residents might be willing to engage in a short ten, fifteen minutes maybe interview but you push it to you half an hour or an hour they lose interest and concentration, lose focus. [Workshop 2, Staff member]

Some residents said that staff members are well placed to complete the surveys on resident's behalf, especially for residents who are non-verbal.

One thing I must say the strength of this place is the people working here and I think that they would be a good. [...] I think you'd get more from them than you would from the residents really. [Resident 14]
Some people can't tell you anything. There's a person in here [...] and you can't communicate with her at all, she'll just start laughing, she's got complete dementia. She's utterly unable to follow anything or answer anything, or even her name, she won't even answer her name. [She] would just giggle or something and walk away. [Resident 7]

However, other residents said that staff should not complete surveys on their behalf, and express concerns about validity.

No, I think it's a bad idea asking the staff. They would probably say that everything is good. Because if they didn't say everything was good, maybe they would get in trouble with the management or something like that. [Resident 24]

*I'm saying that because there are certain staff members who are good, certain who are average and certain who are rats**t³ and I think the rats**t ones would try and colour the answers with answers that they deemed were beneficial to them. [Resident 19]*

4 Discussion

There is little research to date exploring the perceptions of staff, residents, and family members on routine QoL measurement in aged care homes [15]. Most research that does exist focuses on the feasibility of implementing proxy reported rather than self-reported instruments, with most of those studies utilising staff as proxies [14, 29]. This study adds to existing research by investigating the perspectives of aged care staff, residents, and residents' family members on the routine collection of QoL data in residential aged care homes. While participants identified a range of benefits of routine QoL measurement, they also identified implementation challenges and potential validity concerns. These issues highlight important considerations for policy makers and providers when implementing routine QoL measurement in aged care homes.

This study's findings suggest that routine QoL measurement is perceived to be a useful tool for facilitating a person-centred approach to care and care planning, and for supporting quality improvement, which is consistent with other studies [14, 15]. However, maximising this benefit likely depends on the implementation approach. A review by Masso and McCarthy [30] identified the following 'key factors' that facilitate successful implementation of innovations in aged care homes: (i) a receptive context for change, (ii) models for change/implementation, (iii) adequate resources, (iv) staff with the necessary skills, (v) stakeholder engagement, participation and commitment, (vi) compatibility with current practices, (vii) monitoring, feedback and reminder systems, and (viii) demonstrable benefits of the change. Table 2 shows how these factors relate to themes and findings presented in the previous section.

Participants in this study suggested that integration of QoL measurement into existing care plan evaluations provides a model for change that is compatible with current practices. Several staff suggested that consideration of each

³ A vulgar Australian slang term, which here implies that some staff members lack the ability or integrity to perform their job well.

Table 2 Summary of themes, findings, and implementation factors

Theme	Findings	Implementation factors
Benefits of routine QoL measurement	Formalises QoL assessment	Demonstrable benefits of the change
	Identifies possible quality improvements	Stakeholder engagement, participation, and commitment
	Provides stakeholders with information	
Challenges to implementation	Resistance from providers and staff	A receptive context for change
	Perceived as administrative burden	Adequate resources
	Limited time and resources	Stakeholder engagement, participation, and commitment
Best practice for collecting surveys	Integration into care plan evaluation	Models for change/implementation
	Overseen/organised by RN	Staff with the necessary skills
	Flexible administration	Compatibility with current practices
		Stakeholder engagement, participation, and commitment
Validity concerns	Staff focused on task completion	Monitoring, feedback, and reminder systems
	Staff manipulation of data	A receptive context for change
	Residents not receptive	Staff with the necessary skills
	Validity issues with proxies	Stakeholder engagement, participation, and commitment

QoL quality of life, *RN* registered nurse

resident's QoL was already part of care plan evaluations, and introducing routine QoL measurement through a validated instrument would formalise existing ad hoc practices. This accords with prior research, which suggests routine QoL measurement has limited influence on care quality if improvements are not supported by leadership and implemented into providers' policies and practices [31]. It is also consistent with findings from implementation studies in clinical settings, where established workflows may create barriers to QoL measurement if they create competing demands but may be an enabler for implementation where they integrate well into established workflows [18].

Participants' comments also suggested mechanisms for how QoL measurement may entail demonstrable benefits by enabling improvements in quality of care. If collected alongside other information about the residents' health status, mental health, and family and personal circumstances, QoL outcomes can contribute to a holistic interpretation of the residents health and wellbeing [32]. This could also facilitate stakeholder engagement and commitment, as care plan evaluations provide a context in which residents and their families can participate in the interpretation of QoL outcomes and discussion of how this translates into care planning decisions. Residents who are otherwise weary of completing surveys may more readily recognise the benefits of QoL measurement if their responses become a touchstone for conversations about care planning. Our evidence came from one provider, and different providers have different care planning processes, but the benefits of integrating QoL measurement into other planning and assessment processes is relevant to all aged care organisations.

Regarding the receptivity of the context, many participants argued that QoL measurement could face resistance from the sector, particularly by aged care providers who may not want information collected that potentially reflects badly on their performance. Mandatory QoL measurement was generally seen as a positive step that addresses possible resistance, and if outcomes are reported to management or government, might prompt positive changes in the sector. Residents and family members saw benefits to making data publicly available, as it allows potential consumers to evaluate the performance of individual aged care providers and facilitates a more general monitoring of the sector's performance. However, some staff pointed out that existing regulations already impose significant time burdens on providers and staff, on top of other care responsibilities. They suggested that mandatory routine QoL measurement would exacerbate this issue. This situation underscores a conflict in defining implementation barriers [18]: while regulation is perceived as a way of overcoming barriers to QoL measurement, some stakeholders may perceive it as a potential obstacle to delivery of high-quality care [22].

This study's findings reinforce the need for sufficient time and resources to be allocated to QoL measurement as an enabler to ensuring measures are valid and effectively contribute to quality improvements [33], which is consistent with findings from clinical settings [18]. This includes taking a flexible approach to administration by considering residents' individual needs and circumstances, and then planning for an appropriate place, at an appropriate time, with an appropriate member of staff. Regarding staff skills, many participants expressed concerns about the validity of QoL data obtained by front-line care staff. The consensus

among workshop participants was that RNs are best placed to administer QoL surveys. RNs are typically not involved in most hands-on care yet are familiar to residents and have the administrative skills and clinical expertise to ensure surveys are valid reflections of resident's experiences. It was further argued that the RN's position within the care team, located at the intersection between clinical care, administration, and supervision of other staff, meant they were best placed to contextualise findings from QoL measurements and implement changes. This is particularly the case when an RN leads care planning, as this affords a context where QoL outcomes can be discussed with residents and family and translated into positive outcomes for residents and the service more generally. This also allows feedback on implementation of the QoL measurement itself, and consideration of the best approach for the individual resident.

This suggestion contrasts with best practice recommendations that QoL measurement be administered by someone external to the aged care provider [34]. Some comments by proxies and residents suggested that acquiescence bias is possible when residents see a connection between their responses and the performance of a staff member administering the survey. This may be due to fears of repercussions, concerns about implicating individual staff, or a general distrust of providers and staff. Such bias may be mitigated if QoL surveys are administered by independent personnel. However, participants in our study generally argued that QoL measurement is more likely to influence local care practices if administered by leading members of the care team.

4.1 Strengths and Limitations

This study examined the perspectives of staff, residents, and family carers, allowing different stakeholder perspectives on routine QoL measurement. However, workshops were held before our project implemented QoL instruments at their site and our data therefore lacks discussion of different types of QoL instrument and their specific benefits or feasibility issues. The study was also conducted before mandatory routine QoL measurement was introduced as part of the QI Program, so we cannot comment on the roll out. Conducting focus groups allowed participants to build on and respond to each other's ideas within a group dynamic. However, a limitation is that workshop participants can be influenced by the presence of their colleagues and may respond differently in individual interviews. Residents were asked interview questions from this study straight after completing a QoL assessment. While this facilitated residents' understanding of what QoL measurement means, some residents expressed that they were tired, which led interviewers to cut short the questions.

5 Conclusion

While the routine measurement of QoL in aged care homes is seen as a potentially valuable tool for enhancing person-centred care and supporting quality improvement, its successful implementation requires careful consideration of various factors. Integrating QoL measurement into existing care plan evaluations can ensure a holistic approach, but it must be done thoughtfully to avoid becoming a mere 'box ticking' exercise. The positive reception from residents and family members highlights the potential for QoL data to drive sector-wide improvements. However, challenges such as increased surveillance concerns, regulatory burdens, and potential data manipulation must be addressed. Ensuring adequate resources, appropriate timing, and skilled administration are crucial for accurate and effective QoL measurement. Balancing these elements will be key to leveraging QoL data for meaningful improvements in aged care.

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Declarations

Conflicts of interest Lidia Engel, Nancy Devlin, Brendan Mulhern, Tessa Peasgood and Rosalie Viney are members of the EuroQol group that developed the EQ-HWB used in the study. Cate Bailey, Ekaterina Bogatyreva, Frances Batchelor, Briony Dow and Andrew Gilbert have no conflicts of interest that are directly relevant to the content of this article.

Research ethics This study was approved by the Monash University Human Research Ethics Committee (Project ID: 32170). Participants provided written consent prior to interviews or workshops.

Availability of data and material The data generated in the current study are not publicly available but are available from the corresponding author on reasonable request.

Author contributions All authors contributed to the study conception and design. Material preparation and data collection were performed by LE and FB. Data analysis was performed by AG and LE. The first draft of the manuscript was written by AG and LE, and all authors commented on previous versions of the manuscript. All authors approved the final manuscript.

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