



Recommendations for reducing harm and improving quality of care for older people in residential respite care

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Abstract

Objectives: Residential respite care (RRC) is a vital service that supports older people and their informal caregivers to continue to live in the community. Older people in RRC have an increased risk of injury-related harm, such as choking and suicide, compared to permanent nursing home residents. However, the opportunities for the prevention of harm during a RRC admission are largely unknown. This study developed recommendations to reduce harm and improve quality of care for older people in RRC.

Methods: Experts developed, refined and prioritised recommendations through two consultation forums applying the modified nominal group technique and a follow-up online survey. Participants were purposively sampled from an existing network and were selected based on their expertise in aged care practice, nursing, policy, research, caregiver advocacy and quality improvement in the aged and healthcare sectors. Haddon's Matrix, an injury prevention framework, was applied to the recommendations. Final recommendations were released to over 300 organisations for validation and feedback.

Results: Five experts were involved in forum one, seven attended forum two, and a further seven completed the survey. Seventeen draft recommendations were developed and refined to 11 final recommendations, four of which were prioritised as most important for implementation. These included the following: (a) a planned preventative care model of RRC; (b) facilities that specialised in RRC; (c) optimising information gathered on RRC residents; and (d) a standardised procedure for admission, handover and discharge from RRC. We received limited feedback from the organisations, which did not alter the recommendations.

Implications for practice: The recommendations developed in this study provide a valuable basis for the development of strategies to reduce harm and improve care in RRC and are a valuable first step towards improving practice. The next step is to empirically test the suggested recommendations to determine their effectiveness.

KEYWORDS

adverse events, injury prevention, nursing home, quality of care, respite

1 | INTRODUCTION

The rapidly ageing global population poses significant challenges for health, social and ageing policy (United Nations, 2017). Many Organisation for Economic Co-operation and Development (OECD) countries currently employ an "aging in place" policy, which involves a person residing in a place of their choosing as they age (Wiles, Leibing, Guberman, Reeve, & Allen, 2011). This is often viewed as preferential to moving into permanent nursing home care as it maintains an older persons' sense of autonomy, security and social connections (Wiles et al., 2011). Respite care is an important service that can assist older people to continue to age in place by giving their informal caregivers a well-deserved, temporary break from caring (Australian Institute of Health & Welfare, 2015). It can also provide emergency support to caregivers when they are temporarily unable to care due to unexpected illness or poor health (Australian Institute of Health & Welfare, 2015). The current need for respite care in high-income countries is high. For example, in the United States, 34.2 million adults are caring for a person over 50 years (National Alliance for Caregiving, 2015). This is expected to increase as the population, frailty and complexity of health needs of older caregivers and dependent older people grow (Productivity Commission, 2008; World Health Organization, 2015).

This study will focus on residential respite care (RRC) in Australia, which involves a dependent older person having a short-term stay in a nursing home facility either on an emergent (unplanned) or planned basis (Australian Institute of Health & Welfare, 2015). To access RRC, the older person will be assessed by a medical professional, who will determine the level of support required by the older person (Australian Government, 2019). If eligible for RRC, the older person or their caregiver will pay a daily fee for the respite stay, which may be subsidised by the Australian Federal Government depending on the older person's financial situation (Australian Government, 2019).

There is an expectation that the respite care receiver, just like all care receivers, will not come to harm during their stay. However, our previous research has established that premature, injury-related deaths such as choking (e.g. aspiration of food or fluids) and suicide do occur during a RRC admission and that respite residents have an increased risk of these deaths compared to permanent nursing home residents (Willoughby, Kipsaina, et al., 2017). Evidence on non-injury-related outcomes of RRC for older people is largely contradictory (Neville, Beattie, Fielding, & MacAndrew, 2015). Studies have reported improvements, deterioration and no changes, in the mental and physical health and behavioural symptoms of older people who use RRC (Neville et al., 2015).

The reasons for this increased risk of harm during a respite admission and by extension, possible interventions to prevent them, remain largely unknown (Gordon & Bowman, 2018). One possible explanation is that RRC has many care transitions in a short period of time. Care transitions, which involve a person leaving one care setting (such as their personal residence) and moving to another (such as a nursing home), are known to be high-risk periods for inadvertent harm and adverse events (Bray-Hall, 2012). Respite

What does this research add to existing knowledge in gerontology?

- Eleven recommendations to prevent harm and improve quality of care for older people in RRC were developed by experts in aged-care, and guided by Haddon's injury prevention framework.
- Four recommendations were prioritised by participants: (1) planned preventative care model of RRC; (2) facilities specialising in RRC; (3) optimising information gathered on RRC; and (4) standardised procedures in RRC.
- The recommendations add new value to RRC research by, for the first time, identifying opportunities for prevention initiatives and improving quality of care.

What are the implications of this new knowledge for nursing care with older people?

- The recommendations provide directions to close the gaps in care of older people, identified internationally and from the experiences in Australia.
- The recommendations promote a model of RRC that will meet the needs of respite residents and informal caregivers in a way that promotes the caring relationship, and their health and wellbeing.
- As populations become progressively older and people continue to live in their own dwelling for longer, the demand for high quality RRC will increase.

How could the findings be used to influence policy or practice or research or education?

- The recommendations in this study provide a basis for the development of prevention policies and practices to reduce harm and improve care for older people in RRC.
- Future research should empirically test the recommendations developed in this study to determine their effectiveness in reducing adverse events and mortality in RRC.
- Implementation of the recommendations would require a co-ordinated, multisector approach comprising relevant government departments, aged care providers, researchers and clinicians.

involves the dependent older person transitioning from the community to the nursing home and then back again, usually in a period of two weeks (Willoughby, Ibrahim, Ferrah, & Bugeja, 2017). Reasons for the increased risk of harm during a care transition may include failures in communication or transfer of information and inadequate education of primary caregivers (Bray-Hall, 2012). These risks are targeted for interventions in health care by the World Health Organization's (WHO) global initiative to improve patient handover (WHO, 2007). Improving systems of care can reduce adverse events by enhancing the detection and mitigation of

errors, thereby improving outcomes for the care receiver (Thomas, 2000).

This study applies a modified Haddon's Matrix (Haddon, 1980), a commonly used paradigm in the public health field that is useful for developing interventions as it considers the sequence of events and intersecting factors leading to a harm occurring (Runyan, 2003). The traditional Haddon's Matrix considers the intersecting factors relating to the host, agent and environment, and stages in time (pre-event, event, post-event) (Haddon, 1980). In this study, Haddon's Matrix is cross tabulated with domains based on the Social Determinants of Health Framework (physical, social and economic conditions in which people work and live that can impact on health) (Solar & Irwin, 2010). Creating policies that positively impact the social determinants of health can improve health for large numbers of people in ways that can be sustained over time (Solar & Irwin, 2010).

Expert knowledge and skills are vital for improving the quality of care in nursing homes and can provide a crucial first step towards effective strategies and policies that prevent harm to residents (Pike et al., 2015; Tolson et al., 2007). High-quality, evidence-based recommendations require a multidisciplinary development group; consensus processes; clear scope; systematic reviews of evidence (Qaseem et al., 2012); and an assessment of effectiveness and feasibility (Evans, 2003). In this study, the term "recommendation" is used in the medicolegal context, that is to describe concepts that relate to public health or safety and ways to prevent deaths from happening in similar circumstances in the future.

This research addresses gaps in knowledge by developing and prioritising recommendations to reduce harm and improve quality of care among older people in RRC, through consultation with experts and stakeholders.

2 | METHODS

2.1 | Study design

This mixed methods study comprised two expert and stakeholder consultation forums applying a modified nominal group techniques (NGTs) and an online survey (Figure 1).

Consensus methods, such as the NGT, are effective and reliable methods for problem identification and developing recommendations (Harvey & Holmes, 2012). The NGT involves structured face-to-face meetings of ideally six to 12 experts who are tasked with discussing and identify solutions to a particular problem (Harvey & Holmes, 2012). The structured nature of the NGT ensures all participants have an equal opportunity to contribute and prevents the discussion being dominated by a single person (Harvey & Holmes, 2012). We adopted a modified NGT that involved four key stages: (a) introduction and explanation of the issue; (b) group discussion; (c) individual generation of ideas; and (d) voting and ranking (forum one only, final ranking of recommendations was conducted in the online survey).

The study was conducted in accordance with the consolidated criteria for reporting qualitative studies (COREQ) (Appendix 1)

(Tong, Sainsbury, & Craig, 2007). This is a reporting criterion for qualitative studies aiming to standardise and improve the quality of reporting in these studies (Tong et al., 2007).

2.2 | Researcher, facilitator and reflexivity

The primary researcher (MW), the senior researcher (JEI) and an external facilitator (JB) conducted the forums and were not considered participants in the study. The researchers and facilitator had similar demographics: female (MW, JB); tertiary level educated (MW, JEI, JB); and involved in the health (JEI, JB) and aged care sector (JEI). Some of the participants may have known the senior researcher.

2.3 | Theoretical frameworks

Recommendations were developed in accordance with an evidence-based, recommendation formation framework, grounded in public health conceptual models of injury causation and prevention (Bugeja, Ibrahim, Ozanne-Smith, Brodie, & McClure, 2012). This framework outlines the following elements should be included in recommendations to increase successful implementation: target population; risk factors; countermeasures; level of intervention; strategy for implementation; responsible organisation; and timeframes for implementation (Bugeja et al., 2012).

A modified Haddon's Matrix (Haddon, 1980) (previously described) that crossed tabulated three event stages (pre-respite admission, during the respite admission and post-respite admission), with six Social Determinants of Health domains (legislations and policy; physical environment; health sector; technology; community; and staff), was used in developing and analysing the recommendations (Appendix 2).

2.4 | Participant selection

Participants were purposively sampled from the university's extensive existing network and were selected based on their expertise in aged care practice, nursing, policy, research, caregiver advocacy and quality improvement in the aged and healthcare sector in Australia. Characteristics of attending participants are outlined in Table 1. A participant follow-up strategy based on Dillman's protocol (Dillman, 2000) was applied before each of the forums and the online survey. This involved follow-up emails at two and four weeks after the initial invitation and a phone call five weeks after the invitation. It has been shown that multiple contacts with participants increase the response rate (Dillman, 2000). All participants were provided with a plain language statement with the email invitation that stated their acceptance to participate would be taken as an indication of informed consent. Participants did not receive payment for their involvement.

2.5 | Data collection

Data for the formulation of the recommendations were collected over three stages: two forums and an online survey (Figure 1). Each stage is outlined below.

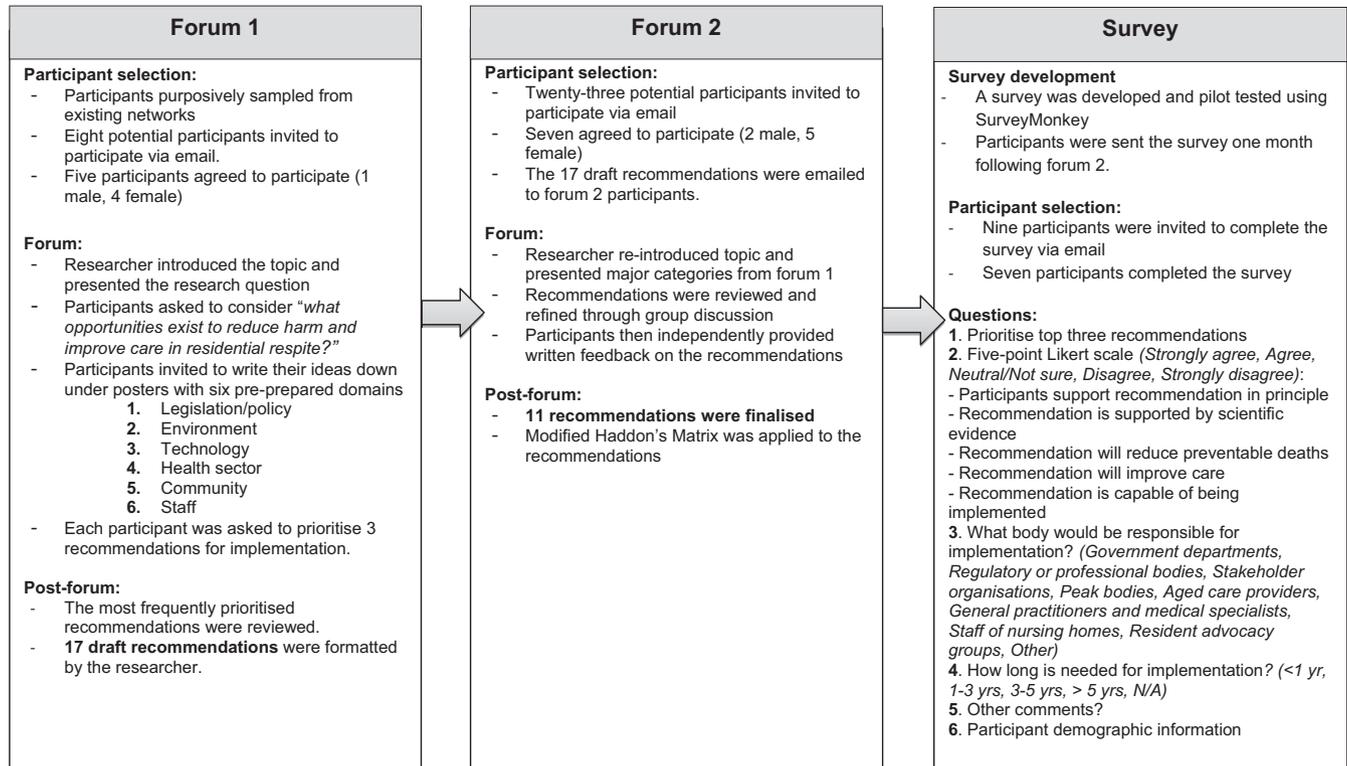


FIGURE 1 Nominal group technique method

2.5.1 | Forum 1

The first forum was held on 21 July 2016 in Melbourne city (Australia) and was conducted over two hours. The purpose of this forum was to generate draft recommendations relating to RRC (Appendix 3). Eight potential participants were invited via email to forum one, of which five attended. For this forum, we purposely sampled people who, through practical experience or academic research, had knowledge of current respite care practices and/or research, such as those with aged care management, nursing, academic or caregiver

advocacy expertise. Results from a previously conducted systematic review (Willoughby, Ibrahim, et al., 2017) and national cohort study (Willoughby, Kipsaina, et al., 2017) were presented to participants at the beginning of the forum to inform discussion. Participants discussed and identified categories and codes within six domains based on the Social Determinants of Health Framework (Solar & Irwin, 2010) (Table 2). The facilitator, who was not considered a participant in the study, directed conversation round the six domains. Participants then independently generated recommendations and were asked to prioritise three recommendations or categories

TABLE 1 Forum participant characteristics^a

#	Sex	Location	Profession	Experience in older people nursing	Forum 1	Forum 2
1	M	Regional Victoria	Nursing home management	✓	✓	✓
2	F	Metropolitan Victoria	Researcher in older people and nursing homes	✓	✓	✓
3	F	Metropolitan Victoria	Nursing home management	✓	✓	✓
4	F	Metropolitan Victoria	Academic in nursing	✓	✓	✓
5	F	Metropolitan Victoria	Advocate of caregivers who use respite care	✓	✓	✓
6	F	Metropolitan Victoria	Quality improvement in nursing homes	✓	✓	✓
7	M	Metropolitan Victoria	Quality improvement in health care	^b		✓
8	M	Metropolitan Victoria	Management in the health of older people	^b		✓
9	F	Metropolitan Victoria	Quality improvement and consumer protection in nursing homes			✓
10	F	Metropolitan Victoria	Quality assurance in nursing homes			✓

^aSurvey participants not included in the table as the survey was conducted anonymously.

^bParticipant has nursing experience in areas other than older people nursing.

TABLE 2 Development of recommendations

Domain	Forum 1	Draft recommendations	Forum 2
	Categories		Final recommendations
Legislation and policy	<ul style="list-style-type: none"> • A review of current model of respite care^a • Improve focus on planned respite^a • More flexibility in respite • Ratio for permanent to respite beds • Patient to staff ratios are needed • More assistance and funding for respite^a 	D 1.4. Respite care should be changed/updated ^c D 1.7. There should be flexibility in terms of what days and length of stay respite residents can be admitted ^c D 2.6. A ratio of permanent to respite beds ^b	1.2. That a planned preventative care model of respite is adopted 1.5. That there is flexibility in when respite residents are admitted and the length stay
Physical environment	<ul style="list-style-type: none"> • Bringing in personal/familiar items • Pets in respite • Consistency in room quality between respite and permanent residents 	D 2.3. Residents should be able to bring in personal items ^e D 2.4. Respite residents receive adequate accommodation and personal contact time ^b	2.2. That respite residents are able to bring in personal and familiar items
Health Sector	<ul style="list-style-type: none"> • Respite be seen as an essential part of the health care continuum • Need to be assessed on admission • A greater application of "in-reach" programs is needed • It is unknown exactly how many people died outside of respite 	D 1.2. The care of respite residents should be included as part of the general running of nursing homes and allocated resources ^b D 2.5. A General Practitioner (GP) should assess respite residents on admission ^c D 2.7. A systematic approach to improve identification and analyses of adverse events ^e D 2.8. That a standardised approach to the investigation of all deaths while in, or within seven days after discharge ^e	1.3. That facilities specialising in residential respite be developed ^d 2.3. That clinicians assess respite residents on admission 2.4. A systematic approach to improve identification, and analyses of adverse events 3.1. That a standardised investigation of deaths while in, or within seven days after discharge
Technology	<ul style="list-style-type: none"> • E-health records^a • Communication systems for staff. For example, smart phones, intercoms • Improve data collection 	D 1.1. A central electronic system that stores medical records ^c D 1.3. Electronic communication systems for aged care workers ^b D 2.1. Data collection on respite residents ^c	1.1. That mandatory use of a central electronic health system is required 2.1. That information gathered on respite residents is optimised
Community	<ul style="list-style-type: none"> • Residents and facilities are part of the wider community^a 	D 2.2. Intergenerational such as cohousing and bringing younger people into aged care ^b	-
Staff	<ul style="list-style-type: none"> • Increased understanding of the impacts, training, tools, advanced care planning, and communication^a • More training and education on understanding respite • The quality of handover is inconsistent^a 	D 1.5. Aged care workers should have demonstrated understanding and care competencies ^b D 1.6. A simplified procedure to support handover ^c D 1.8. Standardised handover procedure relating to medication and care ^c D 3.1. A standard procedure for discharge ^c	1.4. That a simplified procedure is implemented through a standardised handover procedure 2.5. A standard procedure for admission, handover and discharge from respite care

Note: Refer to Appendix 3 for full list of draft recommendations, and Table 3 for final recommendations.

^aCategories flagged as major by participants.

^bRecommendation eliminated.

^cRecommendation refined.

^dRecommendation added.

^eNo changes to recommendation.

(Table 2). The forum was recorded on an audio device, and three researchers took field notes during the forum (MW, BK and MWO).

2.5.2 | Forum 2

The second forum was held on 22 September 2016 in Melbourne city (Australia) and was conducted over two hours. The purpose of this forum was to clarify and refine the draft recommendations generated in forum one. The final recommendations generated in this forum are outlined in Table 3. Twenty-three potential participants were invited via email to forum two, of which seven attended. All of the five participants

who attended forum one were invited to forum two, of which two attended. In addition to the participants who attended the first forum, we purposely sampled people who had experience in quality improvement and/or assurance in health or aged care. Again, results from a previously conducted systematic review (Willoughby, Ibrahim, et al., 2017) and national cohort study (Willoughby, Kipsaina, et al., 2017) were presented at the beginning of the forum to inform discussion. Participants at the second forum debated and revised the draft recommendations generated in forum one and identified any gaps in the recommendations. The facilitator, who was not considered a participant, ensured the discussions stayed relevant to the draft recommendations. Participants

#	Recommendations
1. Pre-Respite admission	
1.1.	That mandatory use of a central electronic system, that stores medical records and information from health and aged care providers (e-health records), is required as part of nursing home accreditation to reduce adverse handover incidents
1.2.	That a planned preventative care model of respite is adopted to maintain the caring relationship and reduce adverse events related to emergent admissions ^a
1.3.	That facilities specialising in residential respite be developed to manage the care of respite residents with complex needs ^a
1.4.	That a simplified procedure, involving identifying five vital care needs of the respite resident, is implemented to mitigate adverse events through a standardised handover procedure.
1.5.	That there is flexibility in when respite residents are admitted and the length of their stay to improve access and use of respite care by caregivers
2. During respite admission	
2.1.	That information gathered on respite residents is optimised to identify how and why respite is used and opportunities to prevent adverse events through enhanced national data collection on respite residents ^a
2.2.	That respite residents are able to bring in personal and familiar items into respite care to create a familiar environment thereby reducing adverse events
2.3.	That clinicians assess respite residents on admission to determine the presence of conditions that may impact the care and health of the respite resident
2.4.	That a national, systematic and coordinated approach be taken to improve identification, reporting, investigation, and analyses of adverse events involving residential respite residents
2.5.	That a standard and comprehensive procedure for admission, handover and discharge from respite care is implemented so that the family, General Practitioner and community services are aware of the needs of the resident during and immediately after respite care ^a
3. Post-respite admission	
3.1.	That a national standardised and coordinated approach to the investigation of all deaths of nursing home residents while in, or within 7 days after discharge from respite care is implemented.

^aRecommendation prioritised as most important for implementation by participants.

then had the opportunity to provide written feedback on the draft recommendations. The forum was recorded on an audio device, and two researchers took field notes during the forum (MW and BK).

2.5.3 | Online survey

The online survey was open for six weeks from 26 October 2016 to 9 December 2016. The purpose of the survey was for participants to rank recommendations and provide final clarifications or feedback. Nine participants (all who attended forum two, and two who were not able to attend the forum but requested to be involved in future stages) were invited via email to complete the survey. Seven participants anonymously completed the survey.

The survey comprised 48 questions in total (Figure 1). For each recommendation, four standard questions were asked (4 × 11 recommendations = 44 questions). The first was a five-point Likert scale to gauge the participants' agreement (strongly agree to strongly disagree) with five statements on the recommendation's

TABLE 3 Final recommendations developed through expert and stakeholder consultation forums

potential effectiveness and feasibility. This was followed by two multiple response questions on what body should be responsible for implementing the recommendation (e.g. Government bodies, professional bodies, aged care providers) and the timeframe needed for implementation (e.g. <1, 1–3, 3–5, >5 year), respectively. Participants also had an opportunity for open-ended comments. The remainder of the survey included one question asking the participants to prioritise and rank three recommendations, and three closed-ended questions collecting demographic information. Further information on the survey questions is outlined in Figure 1. The survey was checked for face validity by two researchers and took approximately 15 min to complete.

2.6 | Analysis

The final recommendations (Table 3) were released to over 300 organisations for feedback and validation, with limited response which did not alter the recommendations. This included all subscribers to

the RAC (Residential Aged Care) Communique which has more than 5,000 subscribers from the aged and healthcare sector (Victorian Institute of Forensic Medicine, n.d.).

2.6.1 | Analysis of the forums

We conducted content analysis, wherein the recordings and field notes from the forums were systematically coded and categorised by meaning (Erlingsson & Brysiewicz, 2017). Recommendations were developed only from the information generated in the forums, without a priori coding scheme. Data saturation was reached such that no new major categories emerged after the review of the data and the replication of responses by participants was present (Morse, 2015).

The final recommendations were revised to ensure they contained all elements outlined in the injury causation and prevention framework (previously described) (Bugeja et al., 2012). Where an element of the injury causation and prevention framework was missing from the recommendation, it was added in by a researcher (MW) based on the field notes and audio recordings of the forums. Two elements of the framework, the responsible organisation and timeframes for implementation, were identified by participants in the online survey.

A modified Haddon's Matrix (Haddon, 1980) was used to analyse the final recommendations to gain an understanding of what respite stage (pre-respite admission, during the respite admission and post-respite admission) participants believed the most prevention work could be done (Appendix 2).

2.6.2 | Analysis of online survey

Survey results were exported from SurveyMonkey into a Microsoft Excel spreadsheet for descriptive analysis. The responses to the Likert scales were summarised as a weighted average calculated to determine the overall consensus of responses by allocating a score to each response and dividing the total by number of respondents (Strongly agree = 5; Agree = 4; Neutral/Not sure = 3; Disagree = 2; Strongly disagree = 1). Where participants were asked to prioritise their top three most important recommendations, a weighted total was also calculated (1st most important = 3 points; 2nd most important = 2 points; 3rd most important = 1 point).

2.7 | Ethics

This study was approved by the Victorian Institute of Forensic Medicine Research Advisory Committee (RAC003/16) and the Department of Justice Human Research Ethics Committee (CF/13/8187).

3 | RESULTS

3.1 | Participant characteristics

Participant characteristics are outlined in Table 1. Of the eight invited participants, five (63%) were involved in forum one. Of the

23 invited participants, seven (30%) attended forum two, and a further seven (78%) out of nine invited participants completed the survey (Table 1). While it was not our intention to have all participants involved in every stage of the study, two participants attended both forums and were invited to complete the online survey. It is unknown whether these participants also completed the survey as it was completely anonymous. Overall, the majority of forum participants were female ($n = 7$, 70%), worked in a metropolitan area ($n = 9$, 90%) and were from a diverse range of professions including aged care practice, nursing, research, caregiver advocacy and quality improvement in the aged and healthcare sector (Table 1). Limited demographic information is available for survey participants as the survey was anonymous. The survey participants comprised three (43%) females and two (29%) males (two (29%) sex unknown) and had a range of 18–25 years' experience in the aged care sector.

3.2 | Category development

Twenty categories across the six domains were generated by participants of which seven were considered major categories (Table 2). The major categories emerged from four of the six domains, including legislation and policy ($n = 3$), technology ($n = 1$), community ($n = 1$) and staff ($n = 2$).

3.3 | Overview of recommendations

From all the categories (major and minor), participants in forum one developed 17 draft recommendations (Appendix 3). These were reviewed by participants in forum two, resulting in six draft recommendations being eliminated, one added, eight refined and three having no change (Table 2). Eleven final recommendations were classified by the researchers according to Haddon's Matrix: pre-respite ($n = 5$), during the respite admission ($n = 5$), and post-respite ($n = 1$) (Table 3 and Appendix 2).

3.4 | Prioritised recommendations

Of the 11 final recommendations, four were prioritised for implementation in the aged care sector (Table 3). Prioritised recommendations were aimed at the pre-respite ($n = 2$) and during respite ($n = 2$) stage of Haddon's Matrix, with no prioritised recommendations aimed at the post-respite stage (Appendix 2). The four prioritised recommendations are examined in detail below:

3.4.1 | Recommendation 1.2: A planned preventative care model of respite is adopted

There was a consensus among the participants that the current model of RRC needed to be reframed with a renewed focus on RRC as a planned preventative care service. To prevent informal caregiver burnout, participants felt there is a need for:

regular planned respite [involving] a two week break every three months to be able to maintain the carer [Australian vernacular for caregiver] relationship at home.

(Forum (F) 1 Participant (P) 5, female)

The use of RRC to maintain the caring relationship was a focus of these discussions. For example, one participant stated:

Who is the customer for respite? Is it the [respite] resident or the carer [Australian vernacular for caregiver]? Or is it both? Or is it actually the care relationship? Your job [in respite care] is to sustain those two people to stay in a caring relationship by provision of adequate substitute care.

(F1 P5, female)

Participants stated that currently, informal caregivers are using RRC as a "last resort" (F1 P4, female) when they are exhausted and physically cannot continue caring. They expressed that families often feel a lot of "guilt" (F1 P4, female) when admitting the care receiver to RRC as there is a perception that they have become too burdensome on the informal caregiver. It was believed a preventative care model of RRC may change this perception and promote RRC as a "normal" part of caring. A barrier identified to implementing this recommendation was the lack of available RRC beds creating a difficulty in accessing regular, planned RRC.

The majority of participants (86%, $n = 6$) "agreed" or "strongly agreed" that they supported this recommendation in principle, believed it was backed by scientific evidence and that it could improve care for the majority of nursing home residents (Table 4). The majority of participants also "agreed" or "strongly agreed" that a planned preventative care model of RRC would reduce deaths in RRC care (71%, $n = 5$). The most commonly selected timeframes for implementation were more than 5 years (43%, $n = 3$) and one to three years (29%, $n = 2$). The group most commonly selected as being responsible for implementation were aged care providers.

3.4.2 | Recommendation 1.3: That facilities specialising residential respite be developed

The development of facilities that specialise in RRC was prioritised as equal most important recommendation for implementation. Participants felt that due to the "short and intense" (F2 P7, female) nature of RRC, the service "needs a hyper vigilant approach" (F2 P7, female). It was seen that specialised facilities would reduce adverse events as they would be specifically targeted to meet the needs of short-stay residents. The participants envisioned a facility where

people might go for a day program then decide to pack their bags and stay there for a few nights.

(F1 P5, female)

An identified secondary benefit of this recommendation was that it could improve access to RRC by increasing the number of dedicated beds. One participant explained:

The availability of respite beds is diminishing and very few facilities have dedicated respite beds anymore. Only when they have a vacancy of a permanent bed they'll pop someone in short term. It's really difficult to access high care respite.

(F1 P5, female)

Participants believed RRC beds were diminishing as RRC is "not an attractive business proposition" (F1 P1, male) compared accommodating permanent residents, who are more profitable for aged care providers as they pay more fees to reside in the nursing home.

The majority of participants "agreed" or "strongly agreed" that they supported this recommendation in principle (71%, $n = 5$) (Table 4). Approximately 70% ($n = 5$) of participants also "agreed" or "strongly agreed" that facilities specialising in RRC was backed by scientific evidence, could reduce deaths in RRC and improve care for the majority of nursing home residents. A government department was selected as the body that should be responsible for implementing the recommendation (86%, $n = 6$). Participants anticipated the complexity of implementing this recommendation, with two indicating implementation would take more than five years (29%), and three stating they were unsure how long implementation would take.

3.4.3 | Recommendation 2.1: That information gathered on respite residents is optimised

Optimising information gathered on RRC residents through a national database was ranked as the second most important recommendation for implementation. The participants stated the lack of information collected in RRC was a major challenge. They advocated for a national database that could "track people through the aged care system" (F1 P1, male). It was thought this would broaden the understanding on how and why RRC is used and identify opportunities for improvement. A number of potential data items to be collected were highlighted, including length of stay, adverse events or hospital admissions, type of admission (planned or emergent), reason for the RRC stay, movement into permanent care, and number and location of previous RRC admissions.

Participants believed a challenge to this recommendation would be determining who is responsible for capturing and interpreting the data. Further, staff would need to be trained on good data collection techniques.

Majority of participants (86%, $n = 6$) either "strongly agreed" or "agreed" this recommendation was backed by scientific evidence and supported this recommendation in principle (71%, $n = 5$). An equal number of participants chose three to five years and more than five years as the timeframe to implementation (29%, $n = 2$). Aged care providers and government departments were selected to be responsible for implementing the recommendation (86%, $n = 6$).

TABLE 4 Survey results, weighted totals and key recommendations

Recommendations	Question 1		Question 2				Question 3		Question 4	
	Weighted total	Ranking	Support in principle	Scientific evidence	Reduced death	Improved care	Feasibility	Other comments made (n)	Group responsible, Type (n)	Timeframe, Years (n)
1. Pre-respite admission										
1.1. Central electronic health system	2	6	3.7	3.6	3.0	3.6	3.1	3	G (5)	>5 (3)
1.2. Planned preventative respite	8	1	4.3	4.2	3.8	4.2	3.8	1	A (4)	>5 (3)
1.3. Facilities specialising in respite	8	1	4.3	4.0	3.8	4.0	3.5	2	G (6)	N/A (3)
1.4. Standardised handover	3	5	4.2	3.7	3.8	4.0	4.0	0	A (5)	1-3, 3-5, >5 (2)
1.5. Admission flexibility	1	7	4.2	4.0	3.3	4.0	3.3	1	A (5)	>5 (3)
2. During respite admission										
2.1. National data collection	6	2	4.3	4.2	3.7	3.8	3.8	3	A, G (6)	3-5, >5(2)
2.2. Personal and familiar items.	0	8	4.2	3.8	3.0	3.7	4.0	0	A (6)	1-3 (3)
2.3. Clinicians assess residents	4	3	4.5	4.5	3.8	4.5	3.8	2	R (4)	1-3, >5 (2)
2.4. Analyses of adverse events	4	3	4.7	4.2	4.2	4.2	4.0	2	G (4)	>5 (2)
2.5. Standardised admission, handover and discharge	6	2	4.8	4.4	3.8	4.6	3.8	0	G, R (4)	1-3, <5 (2)
3. Post-respite admission										
3.1. Standardised death investigation	0	8	4.6	4.0	4.2	4.4	3.8	0	G (5)	>5 (3)

Note: Weighted total: participants were asked to prioritise their top three most important recommendations, a weighted total was calculated: 1st most important = 3 points; 2nd most important = 2 points; and 3rd most important = 1 point

Groups responsible: the most frequent group selected by participants to be responsible for implementation of the recommendation. Participants could select up to three options from the following choices: regulatory or professional bodies (R); aged care providers (A); government departments (G); stakeholder organisations; peak bodies; GPs and medical specialists; staff of nursing homes; resident advocacy groups; or other.

Timeframe: the most frequent timeframe selected by participants for implementation of the recommendation in years. N/A = Unsure/Unable to indicate a timeframe

3.4.4 | Recommendation 2.5: That a standard and comprehensive procedure for admission, handover and discharge from respite care is implemented

A standard and comprehensive procedure for admission, handover and discharge from RRC was ranked equal second most important recommendation for implementation. Participants provided suggestions on how this recommendation could be implemented, such as consistent forms or processes at every RRC facility. Participants stated admission to RRC was challenging as family members are often "in chaos" (F1 P4, female) at admission, making retrieving accurate information on care needs difficult. Further, family members may not have information relevant to the care receiver's will, funeral arrangements or advanced care plans, which are vital to providing person-centred care if an adverse event occurs (Mullick, Martin, & Sallnow, 2013). The admission process is also commonly complex and is different at every facility.

Another challenge identified was the inconsistent quality of admissions and handovers. The quality:

depends on the day you come in. The quality can vary quite significantly. Even the documentation and assessments can vary quite dramatically depending on what staff are on.

(F1 P1, male)

Further, participants stated "discharge reports don't exist" (F2 P6, female) and little-to-no information is given to informal caregivers and general practitioners at discharge from RRC.

The majority of participants supported this recommendation in principle, "strongly agreed" or "agreed" it was backed by scientific evidence and could improve care for the majority of nursing home residents (71%, $n = 5$) (Table 4). A government department and a regulatory or professional body were the organisations selected to be responsible for implementation. There were mixed responses regarding the timeframe for implementation with equal numbers of participants (29%, $n = 2$) choosing both one to three years and more than five years.

4 | DISCUSSION

This study is the third part of a comprehensive examination of adverse events and quality of care in RRC. Our team conducted a comprehensive systematic review (Willoughby, Ibrahim, et al., 2017) and national cohort study (Willoughby, Kipsaina, et al., 2017) which have demonstrated preventable adverse events do occur in RRC. However, very little is known about the incidences or opportunities for the prevention of adverse events in RRC (Willoughby, Ibrahim, et al., 2017). These recommendations provide directions to close the gaps of care identified internationally (Willoughby, Ibrahim, et al., 2017) and the experiences in Australia (Willoughby, Kipsaina, et al., 2017). Experts and stakeholders developed and prioritised 11 recommendations aimed at reducing harm and improving care in RRC. The small number

of recommendations is unlikely to be indicative of the amount of harm reduction and quality of care improvement possible. It is perhaps a reflection of the complexity of the issue, leading to fewer recommendations that could reach consensus. Four of the recommendations were prioritised as most important for implementation by participants.

The need for "a planned preventative care model of respite" was ranked as the most important recommendation for implementation. Participants' perception that informal caregivers largely used RRC only when they desperately needed a break is supported by studies examining caregivers of older people with dementia (Hanson, Tetley, & Clarke, 1999; Neville et al., 2015; Robinson, Buckwalter, & Reed, 2013). Caregivers often delay seeking assistance until the disease is in the late stages and less manageable by the caregiver (Hanson et al., 1999; Neville et al., 2015; Robinson et al., 2013). Further, research has found informal caregivers are not using RRC as often as they could, possibly indicating the current reactive model is not meeting the needs of caregivers (Neville et al., 2015). Promoting regular planned RRC as a positive prevention strategy that supports informal caregivers would be a useful intervention to prevent burnout (Pinquart & Sörensen, 2003) and potentially remove guilt by establishing the service as a normal part of caring. Further, planned RRC may reduce the risk of harm from adverse events for RRC residents. Repeated admissions to the same facility increase the older person's familiarity with the nursing home's specific processes and environment (Ferrah, Ibrahim, Kipsaina, & Bugeja, 2017). Similarly, staff may have more detailed background information and know the care needs from prior admissions. Given failures in communication or transfer of information have been associated with an increased risk for adverse events (Bray-Hall, 2012), the unplanned nature of emergent admissions may increase the risk of adverse events as they reduce the opportunity to collect accurate, detailed and comprehensive information at admission (Bray-Hall, 2012; WHO, 2007). This could result in inadvertent errors in care relating to medications, meals and fluids, and managing behaviour.

However, successful implementation of this recommendation would require RRC beds being available to ensure informal caregivers are able to plan for regular RRC stays. Currently, there is a lack of available RRC beds in nursing homes, and where beds are available, there are long waiting lists (Neville et al., 2015). The number of respite beds available in Australia at any one time is difficult to ascertain as nursing homes can determine how many respite beds they offer and there is no set minimum requirement (Carers Australia, 2017). The majority of informal caregivers in Australia have reported that emergent and planned RRC are difficult to access, with an insufficient number of respite beds available being cited as a primary barrier (Carers Australia, 2017).

The "development of facilities specialising in respite" was also ranked as the most important recommendation for implementation. Specialist facilities may be better placed to develop expertise in caring for older people for a short period of time, thereby reducing errors and adverse events. According to the Social Determinants of Health Framework (Solar & Irwin, 2010), the physical environment can impact a person's health and happiness. Special RRC facilities would need to be designed with the health and mobility of residents in mind. The type (shared or private) and size of the room allocated to the

resident has been found to affect quality of life (Edwards, Courtney, & O'Reilly, 2003). Further, positive interactions and building rapport with aged care workers can improve resident's quality of life, while negative interactions contribute to a poor quality of life (Edwards et al., 2003; O'Connell, Hawkins, Ostaszkiwicz, & Millar, 2012). As participants identified, specialist RRC facilities may increase the number of available RRC beds. This may assist governments in ensuring there are adequate numbers of RRC beds available to meet the demand.

There is some evidence to suggest that specialist facilities for people with dementia (Kovach, Weisman, Chaudhury, & Calkins, 1997), hepatitis C (Brenner, Gray, Cama, & Treloar, 2013) and ovarian cancer (Tracey, Hacker, Young, & Armstrong, 2014) do improve care, access to care and quality of life. In contrast, other studies did not find differences between specialist facilities for dementia (Reilly et al., 2006) and alcohol and other drug treatments (Copeland, Hall, Didcott, & Biggs, 1993) and non-specialist facilities. Further, specialist centres may restrict the physical and geographical availability of RRC making it less accessible (Gulliford et al., 2002). Participants noted the complexity of implementing this recommendation. We speculate challenges to implementation may be related to investment in infrastructure, need for new building stock, policy and financial reforms for the specialist facilities. Further, the participants in our sample had backgrounds in aged care, nursing and policy, not business innovation and planning, which may have influenced the results.

"Enhanced national data collection on respite residents" was ranked as the second most important recommendation for implementation. Improving data collection and access in the aged care sector has been recommended elsewhere (Productivity Commission, 2011). Participants in this study recommended collecting data on length of respite admission, type and causes of any adverse events or hospital admissions, type of respite admission (planned or emergent), reason for the RRC stay, movement into permanent care, and number and location of previous RRC admissions. High-quality data collection and analysis is paramount to identifying the root causes of adverse events and measuring service outcomes (Chen, Hailey, Wang, & Yu, 2014; The United Nations International Children's Emergency Fund, 2007). It can also assist in appropriate decision-making, such as allocating funds, informing evidence-based policies and reducing critical gaps in ageing research (Chen et al., 2014; Productivity Commission, 2011). This recommendation could be achieved through a national aged care data clearinghouse which would coordinate, store and distribute aged care data and facilitate access for researchers, policymakers and the community (Productivity Commission, 2011). It has been suggested that an independent regulatory agency should be central to the collection and distribution of the data (Productivity Commission, 2011). This data could also be linked to other relevant health and welfare data sources (Productivity Commission, 2011).

"A standard and comprehensive procedure for admission, handover and discharge from respite care" was ranked equal second most important recommendation for implementation. In nursing homes, adverse events have found to be consistently higher during all transition periods, such admission and discharge (Doupe et al., 2011). During admission, handover and discharge, the care of the RRC resident is transferred from the informal caregiver to the RRC facility and back again. Errors in

handover procedures can lead to an increased risk of hospitalisation and morbidity (Segall et al., 2012; de Vries, Ramrattan, Smorenburg, Gouma, & Boermeester, 2008) and are often due to poor communication (World Health Organization, 2007). Standardised handover communication strategies and systems processes lead to improved safety and consistency, reduce errors and are recommended by the WHO (World Health Organization, 2007, 2013). Successful admission, handover and discharges involve logistical arrangements, education of the RRC resident and/or their caregiver, and coordination among the health professionals involved in the transition, such as the nursing home staff and the RRC resident's general practitioner (Bray-Hall, 2012). This recommendation could be achieved through measures that have been successful in other settings, for example, developing a minimum dataset for discharge handover or supporting face-to-face handover with structured written material such as a checklist (Patient safety centre, 2009).

4.1 | Strengths and limitations

This study had a sound method, followed recognised systems and frameworks (modified NGT and Dillman protocol) (Black et al., 1999) and reporting criteria (COREQ) (Appendix 1). It contributes vital knowledge and insights from a diverse range of experts and stakeholders in the fields of aged care practice, nursing, research, caregiver advocacy and quality improvement in the aged and healthcare sectors. While the number of participants involved in the study was small, previous research suggests the optimal size of a nominal group is between six and 12 participants (Harvey & Holmes, 2012). Further, there were opportunities for feedback from hundreds of organisations and thousands of individuals. While use of the Dillman protocol optimises the response rate, it does not achieve consensus between the experts and stakeholders. Future research should give consideration to the using of a Delphi process which is more robust to achieving consensus recommendations. Additionally, future studies should consider consumer perspectives in improving the quality of care in RRC. This study was not able to empirically test the recommendations for effectiveness, and the suggested strategies for implementation are speculative. The NGT is a highly adaptable method, and as such, a wide range of modifications to this method have been used (McMillan, King, & Tully, 2016). These approaches may not always be generalisable due to the resources available or the specific research topic (McMillan et al., 2016). It is most likely that the specific NGT approach used will influence the recommendations generated (Gustafson, Shukla, Delbecq, & Walster, 1973). A challenge in generalising the recommendations is the uniqueness of the regulation and reimbursement frameworks to the sector in Australia. While the principles underlying the recommendations are worthy of consideration in other high-income countries, the transferability must always be explicit about the context of practice.

4.2 | Implications

The recommendations developed in this study provide a basis for the development of strategies to reduce harm and improve care in RRC. While the formulation of new recommendations does not

automatically lead to change, it is a first step towards improving practice. The next step is to empirically test the suggested recommendations to determine their effectiveness in reducing harm and mortality in RRC. Implementation would require a coordinated, multisector approach comprising relevant government departments, aged care providers, researchers and clinicians. The recommendations will help to generate public debate and inform policy development on the quality, safety and delivery of RRC for older people. As populations become progressively older, and people continue to live in their own dwelling for longer, RRC must be prepared to meet the needs of this population in a way that promotes a person's safety and overall well-being.

Implications practice

- Implementation of these recommendations may assist nursing home staff, providers and policy makers to deliver improved care that is more aligned with contemporary needs of respite care residents.
- Leadership from nursing professionals is important to reduce harm to older persons during residential respite care.
- These new recommendations could be translated into policy, practice and care standards to be monitored and enforced.

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CONFLICT OF INTERESTS

The authors are affiliated and employed by the Department of Forensic Medicine, Monash University, which is also a funding source. The authors have no other potential financial or personal interests that may constitute a source of bias.

AUTHOR CONTRIBUTIONS

Conception and development of the ideas (JEI as the senior author and MW), acquisition of data, analysis and interpretation of data (MW, MHW, CY, JEI), drafting and critical revision of article draft and final approval of the version to be published: (JEI, MW, MHW and CY and MHW). All authors contributed substantially to the intellectual substance of the manuscript and are in full agreement regarding its content.

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APPENDIX 1

CONSOLIDATED CRITERIA FOR REPORTING QUALITATIVE STUDIES (COREQ): 32-ITEM CHECKLIST

No.	Topic	Guide questions/description	Location in text
Domain 1: Research team and reflexivity			
Personal characteristics			
1.	Interviewer/facilitator	Which author/s conducted the interview or focus group?	Page 9, para 1
2.	Credentials	What were the researcher's credentials? <i>Eg PhD, MD</i>	Page 9, para 1
3.	Occupation	What was their occupation at the time of the study?	Page 9, para 1
4.	Gender	Was the researcher male or female?	Page 9, para 1
5.	Experience and training	What experience of training did the researcher have?	Page 9, para 1
Relationship with participants			
6.	Relationship established	Was a relationship established prior to study commencement?	Page 9, para 1
7.	Participant knowledge of the interview	What did the participants know about the researcher? <i>Eg personal goals, reasons for doing the research</i>	Page 9, para 1
8.	Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? <i>e.g. Bias, assumptions, reasons and interests in the research topic</i>	Page 9, para 1
Domain 2: study design			
Theoretical framework			
9.	Methodological orientation and Theory	What methodological orientation was stated to underpin the study? <i>e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis</i>	Page 9, para 2
Participant selection			
10.	Sampling	How were participants selected? <i>e.g. purposive, convenience, consecutive, snowball</i>	Page 9, para 4
11.	Method of approach	How were participants approached? <i>e.g. face-to-face, telephone, mail, email</i>	Page 9, para 4
12.	Sample size	How many participant were in the study?	Page 14, para 3
13.	Non-participation	How many people refused to participate of dropped out? Reasons?	Page 14, para 3
Setting			
14.	Setting of data collection	Where was the data collected? <i>e.g. home, clinic, workplace</i>	Page 10, para 2
15.	Presence of non-participants	Was anyone else present besides the participants and researchers?	Page 9, para 1
16.	Description of sample	What are the important characteristics of the sample? <i>e.g. demographic data, date</i>	Table 1
Data collection			
17.	Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	Page 10, para 3
18.	Repeat interviews	Were repeat interviews carried out? If yes, how many?	N/A
19.	Audio/visual recording	Did the research use audio or visual recording to collect the data?	Page 10, para 2
20.	Field notes	Were field notes made during and/or after the interview or focus group?	Page 10, para 2
21.	Duration	What was the duration of the interviews or focus group?	Page 10, para 2
22.	Data saturation	Was data saturation discussed?	Page 12, para 1
23.	Transcripts returned	Were transcripts returned to participants for comment and/or correction?	N/A
Domain 3: analysis and findings			
Data analysis			
24.	Number of data coders	How many data coders coded the data?	N/A
25.	Description of the coding tree	Did authors provide a description of the coding tree?	N/A
26.	Derivation of themes	Were themes identified in advance or derived from the data?	Page 12, para 1
27.	Software	What software, if applicable, was used to manage the data?	Page 12, para 4
28.	Participant checking	Did participants provide feedback on the findings?	N/A
Reporting			
29.	Quotations presented	Were participant quotations presented to illustrate the themes/ findings? Was each quotation identified? <i>e.g. participant number</i>	Page 14– Page 19
30.	Data and findings consistent	Was there consistency between the data presented and the findings?	Page 14–Page 19; Table 2
31.	Clarity of major themes	Were major themes clearly presented in the findings?	Table 2
32.	Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	Table 2

APPENDIX 2

MODIFIED HADDON'S MATRIX

Event	Legislation and policy	Physical environment	Health sector	Technology	Community	Staff
Pre-respite	1.2. Planned preventative care model 1.5. That there is flexibility in when respite residents are admitted and the length stay.	-	1.3. That facilities specialising residential respite be developed	1.1. That mandatory use of a central electronic health system is required.	-	1.4. That a simplified procedure is implemented through a standardised handover procedure.
Respite	-	2.2. That respite residents are able to bring in personal and familiar items.	2.3. That clinicians assess respite residents on admission. 2.4. A systematic approach to improve identification, and analyses of adverse events.	2.1. That information gathered on respite residents is optimised	-	2.5. A standard procedure for admission, handover and discharge from respite care
Post-respite	-	-	3.1. That a standardised investigation of deaths while in, or within seven days after discharge.	-	-	-

Recommendations prioritised as most important for implantation by participants.

APPENDIX 3

DRAFT RECOMMENDATIONS DEVELOPED IN FORUM 1

#	Recommendations
1. Pre-respite admission	
D1.1.	A central electronic system that stores medical records and information from health providers and nursing homes (e-health records), to reduce adverse handover incidents for respite residents
D1.2.	The care of respite residents is a core service and as such should be included as part of the general running of nursing homes and allocated the resources necessary to ensure care is at the same standard as permanent residents
D1.3.	Electronic communication systems for aged care workers should be installed to support aged care workers in caring for respite residents by improving communication
D1.4.	The current model of respite care should be changed/updated with greater emphasis on respite as planned preventative care to maintain the caring relationship and reduce adverse events related to emergent admissions
D1.5.	Aged care workers should have demonstrated understanding and the care competencies for managing the impact of respite care on the carer and resident to reduce the stress related to respite admission.
D1.6.	A simplified procedure to support handover, "the 5 most important things" should be implemented to enabling aged care workers to quickly familiarise themselves with the respite resident, their needs and medication and avoid adverse events related to handover
D1.7.	There should be flexibility in terms of what days respite residents can be admitted and the length of stay to improve access and use of respite care by carers
D1.8.	Standardised handover procedure relating to medication and care be implemented
2. During respite admission	
D2.1.	Data collection on respite residents should be improved to identify how respite is used and potential adverse events.
D2.2.	Intergenerational programs should be implemented in nursing homes that involve respite residents such as cohousing and bringing younger people into aged care space to combat ageism and encourage positive community engagement in nursing homes
D2.3.	Respite residents should be able to bring in personal, familiar items into respite care to ensure their stay is enjoyable and a less stressful experience
D2.4.	Respite residents should receive adequate accommodation and personal contact time with aged care workers to ensure they receive a high quality of care

(Continues)

APPENDIX 3 (Continued)

#	Recommendations
D2.5.	A General Practitioner (GP) should assess respite residents on admission to detect any possible conditions that may impact the care and health of the respite resident
D2.6.	A ratio of permanent to respite beds should be implemented in nursing homes to ensure carers and dependant older people have adequate and timely access to respite care to reduce stress and enable planned respite care
D2.7.	That a national, systematic and coordinated approach be taken to improve identification, reporting, investigation, and analyses of adverse events involving residential respite care among nursing home residents
D2.8.	That a national standardised and, co-ordinated approach to the investigation of all deaths of a nursing home resident while in, or within seven days after discharge from respite care is required
3. Post-respite admission	
D3.1.	A standard and comprehensive procedure for discharge from respite care is required so that the family, general practitioner and community services are aware of the outcomes during respite care