RESEARCH ARTICLES

Understanding aged care emergency department presentations: The voices of nurses from residential aged care facilities

AUTHORS

CLINT MOLONEY RN, BN, MHRM, PhD[1,3]
GAVIN BECCARIA BSc, AP, MPS, PhD[2,3]
HANCY ISSAC RN, BNur, MRes, PHD[4]
VICTORIA TERRY RN, BNur, MRes, PHD [1,3]
MELISSA TAYLOR RN, BNur, MRes, PHD [1,3]

1. School of Nursing and Midwifery, University of Southern Queensland, Toowoomba, Queensland, Australia
2. School of Psychology, University of Southern Queensland, Toowoomba, Queensland, Australia
3. Centre for Health Research, University of Southern Queensland, Toowoomba, Queensland, Australia
4 Faculty of Health, Nursing, Southern Cross University, Gold Coast, Queensland, Australia

CORRESPONDING AUTHOR

CLINT MOLONEY School of Nursing and Midwifery, University of Southern Queensland, West St, Darling Heights, Toowoomba, QLD, Australia. 4350. E: moloney@unisq.edu.au

ABSTRACT

Objective: To explore the perceptions of registered nurses and personal care workers in residential aged care facilities (RACFs) regarding factors contributing to early clinical deterioration and potentially unnecessary hospital presentations.

Background: Persistent workforce shortages, inadequate staffing levels, inconsistent care standards, and suboptimal communication in RACFs contribute to increased hospital transfers. However, many hospital presentations from RACFS are unwarranted and avoidable, and many residents could be better treated by alternative means in place.

Study design and methods: This study used a qualitative methodology in which semi-structured focus groups with registered nurses and personal care workers from two private RACFs in Queensland were used to gather in-depth accounts of experience and perceptions. Data was analysed using Braun and Clarke's reflexive thematic analysis approach.

Results: Four major themes emerged: 1) Clinical decision-making and confidence under pressure, with RNs reporting low confidence and anxiety regarding whether or not to transfer; 2) Organisational and interprofessional dynamics, with staff describing tensions with emergency and ambulance services; 3) Clinical reasoning and support structures, where staff described the value of Nurse Practitioners and clinical guidelines in decision making; 4) PCW role clarity and communication, where uncertainty about scope of practice and fragmented handover procedures were described.

Conclusion: Hospital transfer decisions in aged care are complex and heavily influenced by the experience and confidence of Registered Nurses (RNs). Less experienced RNs tend to make more cautious decisions, sometimes leading to avoidable transfers. Nurse Practitioners (NPs) help support better decisions, but organisational pressures and unclear roles, especially for Personal Care Workers (PCWs), create challenges. These factors collectively promoted risk-averse decision-making and increased reliance on hospital transfers. Improving training, clarifying roles, and fostering teamwork can reduce unnecessary transfers and improve care quality.

 https://doi.org/10.37464/2025.424.1806

Implications for research, policy, and practice: There is a need to further investigate the impact of RN experience levels on hospital transfer rates. More attention needs to be given to developing effective models for integrating NPs into aged care teams. Further study the role and training needs of PCWs in early detection and decision-making.

What is already known about the topic?

- Up to 40% of hospital transfers from aged care facilities are potentially avoidable, often due to limited on-site clinical support and decision-making confidence.
- Newly graduated or less experienced RNs may lack the clinical reasoning skills needed to confidently manage acute situations, leading to more frequent hospital transfers.
- Poor communication between aged care staff, emergency services, and hospitals can hinder effective care transitions and lead to unnecessary hospitalisations.
- Ongoing staff shortages and increased demand for skilled nurses place pressure on existing staff, affecting the quality and timeliness of clinical decisions.

What this paper adds

- Confirmation that additional resources are required to better enable an early response for the assessment of residents with deteriorating health.
- A clear indication that communication processes need to improve between PCWs and RNs in the recognition of resident symptoms and any health deterioration.
- That PCWs could play a more integral role in reducing unnecessary hospital transfers through a more evolved scope of practice.

Keywords: Residential aged care, Registered nurses, Personal care workers, Clinical deterioration, Hospital transfers, Decision-making, Workforce shortages, Communication.

OBJECTIVE

To explore the perceptions of registered nurses (RNs) and personal care workers (PCWs) working in residential aged care facilities (RACFs) regarding the contributing factors towards potentially avoidable presentations to the hospital. Specific areas of focus included:

- Clinical considerations and practices when a resident's health is deteriorating.
- Resources needed to support clinical decision making when a resident's health is deteriorating.
- Available processes, both internal and external, to assist with decision making, including hospital outreach programs to mitigate avoidable hospital transfers from RACFs.
- Barriers encountered in managing residents in the RACF when they become clinically unwell.
- The degree of confidence in managing residents who are clinically deteriorating.
- Factors influencing decisions to transfer a resident to a hospital.
- Perceptions of their own and their colleagues' capabilities in recognising acute deterioration in residents.

BACKGROUND

The quality of care delivered in Australian RACFs is concerning for residents.[1-4] With a rapidly ageing population, urgent reform is crucial, as has been noted by the Royal Commission into Aged Care Quality and Safety.[6] Literature has highlighted that, due to increasing care complexities, facilities are now evolving to become sub-acute institutions with increasing complexities of care.[5-7] However, this increase in acuity has occurred without an appropriate workforce capability assessment, which has been linked to an increased risk of 'failure to rescue'.[8] A failure to rescue has been defined in the literature as "the failure to prevent a death resulting from a complication of medical care or from a complication of underlying illness or surgery."[8(pp1)]

Nursing care provided by RACF staff is documented as failing to meet professional nursing standards. A failure to meet these standards is known to adversely affect safe quality care, thereby compromising a resident's health and leading to unnecessary hopsitalisation.[7,9,10] A key driver of this problem is inadequate staffing ratios, which leave staff without sufficient time or resources to deliver required care.[11,12] Actual resident to PCW ratios vary between facilities based on size, funding, and staffing availability, and each facility must now have an RN on-site and on duty 24 hours a day, 7 days a week.[5,6] According to Australia's aged care sector full-year report (2024), and the Australian Institute of Health Welfare's (2024) report on staff ratios, current staffing ratios need to be increased to meet the desired care standards.[11,12]

A report led by the Committee for Economic Development of Australia (CEDA) warns that workforce shortages in the Australian aged care sector may reach 400,000 by 2050, signalling an escalating system-wide crisis.[13] These shortages are already contributing to sub-standard care delivery within RACFs, with significant implications for resident safety and wellbeing.[4] As staffing numbers decline, the capacity

 https://doi.org/10.37464/2025.424.1806

of aged care services to recognise, assess, and respond to clinical deterioration, particularly in increasingly common sub-acute presentations, becomes further constrained. To address concerns about care quality and meet rising sub-acute demands, workforce recruitment and retention must be accompanied by strengthened clinical capability development, ensuring RACF staff are supported to build confidence, competence, and decision-making skills in assessing and managing sub-acute situations, thereby reducing hospitalisation.[7-14]

There have been long-standing calls for minimum standards surrounding workforce knowledge and skill mix to enable quality nursing care standards for residents.[10-12] Poor communication and assessment between PCWs, RNs, and medical practitioners have contributed to sub-optimal care.[13-15] The disparities exposed by prior research demonstrate that it is imperative to improve staff capabilities in the detection of a resident's health deterioration.[18] The role that PCWs play in the earlier detection of deterioration needs greater exploration.[16] Further, investigating ways to improve clinical reasoning skills in this workforce needs to be at the forefront of changes in the sector.[16,17] Importantly, RNs working in the aged care sector require opportunities to further develop and grow experience in making decisions around hospital transfers.[18,19]

Many hospital presentations are unwarranted, where residents could have been treated in situ or by alternative means.[20-22] Despite the ever-increasing number of hospital presentations for frail older people, there has been no solution or model of care for frail older people in the setting of emergency care or in the discharge planning phase of care.[23] Recent research refers to a need to incorporate more targeted case management for individuals with chronic health conditions to reduce the need for hospital presentations.[24] What is clear from the literature is that nurse practitioners (NPs) may play a central role in providing this necessary case management, complementing the role of general practitioners in monitoring for changes in a resident's health status.[25] This, in turn, may help to better support RACF nursing staff with the ongoing monitoring and assessment of residents with chronic health conditions.[18]

This gap between planning and delivery also appears to have its origins within the role that PCWs play in assessment and communication of resident issues.[26,27] A growing decline in care standards and staffing levels regarding the value of recognising deterioration amongst residents by PCWs is a disguised contributor to deteriorating health for residents.[26,27] Under-prepared skill mix and staffing numbers appear to be undermining quality care and have led to instances of failure to rescue.[8,28] Consequently, this research recommended greater exploration of PCWs' core skills and practices within the context of appropriate guideline integration into care delivery by PCWs may impact the ability of these staff to better assess and report issues to RN's for intervention.[15]

The Australian Council of Nursing (ACN) embraces the concept that a suitably skilled and safe aged care workforce is primarily linked to an improved delivery of appropriate care.[29] There is a direct inverse association between nurse-to-patient ratios and patient deterioration and subsequent mortality.[33] Higher ratio of RNs to patients was associated with lower patient morbidity and mortality.[30] Nevertheless, the role of PCWs in detecting early deterioration has never been considered.[28,31,32]

STUDY DESIGN AND METHODS

This study used a qualitative approach. Focus with RNs and PCWs who work in RACFs and who had experienced situations of resident health decline and transfer to an emergency department were engaged in the research. Focus groups were semi-structured and guided by a set of promoting questions (Table 1).

Focus groups were chosen to explore the voices of residential aged care RNs and PCWs to better establish contributing factors towards unnecessary presentations to emergency departments (ED).

SETTING

Organisational permissions were sought from two private aged care facilities in the Ipswich region of Queensland, where flyers were distributed in the facilities to seek participation in focus group sessions.[33]

RECRUITMENT AND PARTICIPANTS

Using convenience sampling, a total of 12 RNs and 12 PCWs were recruited to participate in the study. The participants were organised into two RN groups and two PCW groups, each of which engaged in three focus group sessions conducted over a six-month period. To encourage equal participation and candid discussion, the groups were deliberately composed of homogeneous staff members of similar status and grade.[36,37] Senior supervisory staff were excluded from participation to create a safe environment where individuals felt comfortable sharing their perceptions, experiences, and concerns openly.[37]

Participation in the focus groups was voluntary, and all participants attended the full series of three sessions, except for one individual from Group 4 who was unable to attend the final session due to illness. Further details regarding the focus groups are provided in Table 2.

DATA COLLECTION

Focus groups were conducted face-to-face in a setting comfortable to the participants. Open-ended questions and facilitator prompts were developed by the research team and used to provide an opportunity for participants to provide an in-depth account of their experience and perceptions.

Three focus group intervals (pre, mid and end point) were conducted. Each focus group lasted approximately 1 hour in duration.

Groups were moderated (facilitated) by an experienced qualitative researcher. The researcher acted as group facilitator with the purpose of introducing topics (see Table 1) and guiding discussion around the agreed area of interest.[28] Using the technique of in-depth discussion, the participants' lived experiences, opinions, attitudes, ideas, and self-realisation were gathered. In-depth discussions enabled deeper questioning by progressing a cyclical process through continuous analysis.[33,34]

TABLE 1. FOCUS GROUP QUESTIONS FOR RNS AND PCW GROUPS

Question sequence	Specific question
Introductory Question:	Can you tell us what the usual clinical considerations and practice are when a resident's health is deteriorating?
Transition question:	What tools do you have to support you with clinical decision-making when a resident's health is deteriorating?
Transition question:	What processes do you have available to you to assist with decision-making for residents?
Focus questions:	Are there any barriers to managing residents in the RACF when they are becoming clinically unwell? How confident are you in managing residents who are clinically deteriorating?
Summarising question:	So, when are you deciding to transfer residents to the hospital? What drives this decision-making, and do you have some examples?

TABLE 2. PARTICIPANT'S YEARS OF EXPERIENCE IN THE AGED CARE SECTOR

Participant Type and Number	Range of Experience
Focus group 1 Registered Nurses RNs 1, 2, 3, 4, 5, 6	Ranged from 1 year of experience to over 30 years of experience in the aged care sector.
Focus Group 2 RNs 7, 8, 9, 10, 11, 12	Ranged from 2 years of experience to over 35 years of experience in the aged care sector.
Focus group 3 PCWs 1, 2, 3, 4, 5, 6	Ranged from 6 months of experience to over 15 years of experience in the aged care sector.
Focus group 4 PCWs 7, 8, 9, 10, 11, 12	Ranged from 1 year of experience to over 20 years of experience in the aged care sector.

DATA ANALYSIS

Braun and Clarke's six-stage approach was used to guide an inductive thematic analysis of the focus group datasets. This method was selected for its flexibility and suitability in exploring participant experiences and meaning-making.[37,38] Audio-recordings were professionally transcribed verbatim, checked against recordings for accuracy, and imported into NVivo qualitative data analysis software to support systematic coding, data organisation, and retrieval.[39,40] The analysis commenced with repeated reading of transcripts and written field notes to achieve familiarisation with the data, during which initial reflections and analytic observations were documented. In the second stage, initial codes were generated inductively, staying close to participants' language and prioritising semantic content to ensure that meaning was grounded in the data rather than imposed by researcher assumptions. Coding was iterative, and transcripts were revisited multiple times as understanding deepened.

In stage three, coded extracts were reviewed collectively to identify patterned responses across participants, and potential themes were constructed by grouping conceptually similar codes. Stage four involved reviewing, refining, and collapsing themes to ensure coherence, internal consistency, and clear distinctions between thematic categories, while checking interpretations against the full data set. During stage five, themes were clearly defined, named, and mapped to illustrate relationships, scope, and explanatory value. The final stage involved producing a detailed analytic narrative supported by data excerpts, demonstrating how themes addressed the research aim and reflected shared and divergent participant perspectives. Throughout the analytic process, reflexive discussions occurred among the research team to challenge assumptions, enhance credibility, and ensure transparency, forming a documented audit trail consistent with qualitative rigour.[37,38]

ETHICAL CLEARANCE

Ethics approval was obtained from the West Moreton Hospital and Health Service, Human Research Ethics Committee. Approval Number: HREC/2018/QWMS/44525. Informed written consent was obtained prior to participation, and participants were advised of their right to withdraw without penalty or prejudice at any time. They were also assured of anonymity and confidentiality of findings through the de-identification of findings.

RESULTS

LATENT INTERPRETATION SUMMARY

While participants provided direct statements about the factors influencing hospital transfers, underlying these were complex dynamics of professional identity, organisational culture, systemic inadequacies, and interprofessional tension.

The latent content of their voices suggests a pervasive sense of vulnerability and moral distress among RNs, who feel responsible for resident outcomes yet are inadequately supported in clinical decision-making. This reflects a broader systemic undervaluing of clinical expertise within aged care, negatively affecting staff morale and the quality of

resident care. At the same time, ambiguity and fragmentation surrounding the role of PCWs signal ongoing challenges with role clarity and capability development within multidisciplinary teams. Organisational pressures and perceived surveillance of clinical decisions further contribute to a risk-averse culture, which may unintentionally undermine resident-centred care. Compounding these issues are disrupted communication loops and gaps in real-time clinical reasoning and escalation pathways, particularly during after-hours periods, increasing the likelihood of delayed or unnecessary hospital transfers.

THEMATIC ANALYSIS OF FACTORS CONTRIBUTING TO HOSPITAL TRANSFERS IN AGED CARE SETTINGS

This thematic analysis explored the latent meanings behind participant narratives, grouping insights into broader themes that reflect the complex interplay of personal, professional, and organisational dynamics involved in hospital transfer decisions.

Four overarching themes were identified: (1) Clinical Decision-Making and Confidence Under Pressure, (2) Organisational and Interprofessional Dynamics, (3) Clinical Reasoning and Support Structures, and (4) PCW Role Clarity and Communication. Each theme is supported by participant quotations to illustrate how meaning was constructed and shared across participants.

Theme 1: Clinical Decision-Making and Confidence Under Pressure

A consistent undercurrent throughout participants' accounts was the uncertainty nurses experience when making clinical decisions under pressure. The latent meaning emerging here reflects how confidence, experience, workload, and limited organisational support influence transfer decisions. Less experienced RNs frequently felt unprepared to manage complex clinical situations independently.

As one RN (10) reflected, *"One contributing factor to ED transfers may be that RNs come straight from being a grad and go into aged care first with very little clinical experience,"* while a PCW (7) noted, *"Most of the registered nurses wouldn't know what to do because they don't deal with PEGs [percutaneous endoscopic gastrostomy tubes] often enough, so they end up in hospital."*

These excerpts reveal how confidence deficits directly shape decisions to transfer residents, even when nurses may possess the capability to manage care in-house.

Uncertainty further compounds this issue. Participants described hesitation and fear of being judged by emergency or ambulance staff for unnecessary transfers.

One RN (9) shared, *"I do still hesitate though as I am always asking myself will the ED staff or the QAS see this transfer as necessary,"* highlighting the emotional weight of clinical accountability.

Time and workload constraints intensified this dynamic, with RN (5) asking, *"Do they have time to assess this resident [referring to general practitioners]? If not, I'll need to send them to hospital because I don't have the time."*

Such reflections underscore how systemic workload pressures can override clinical reasoning, resulting in risk-averse decisions favouring hospital transfer.

Theme 2: Organisational and Interprofessional Dynamics

Organisational scrutiny and interprofessional misalignment were powerful influences on decision-making. The latent meaning here suggests that institutional oversight and hierarchical pressures can erode nurses' autonomy, leading to defensive practices. Participants spoke candidly about being reprimanded for their decisions:

"Management above the RN had a go at them because they weren't sick enough to go to hospital," one PCW (4) explained. Similarly, *"Facilities don't like them going off to hospital unless it's really necessary,"* another RN (8) added.

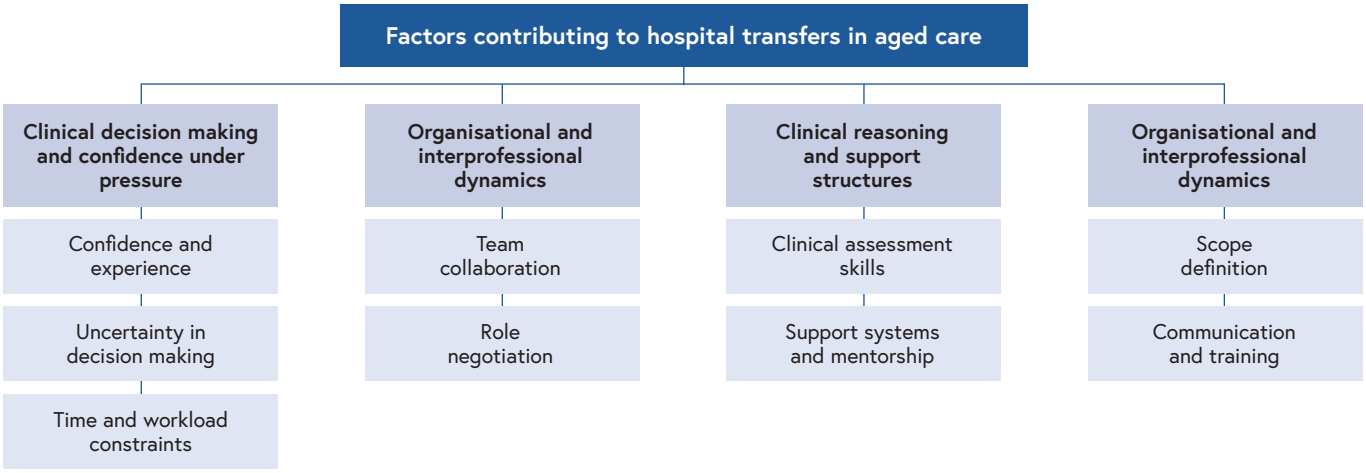

FIGURE 1. FACTORS CONTRIBUTING TO HOSPITAL TRANSFERS IN AGED CARE

 https://doi.org/10.37464/2025.424.1806

This scrutiny created a culture of fear and second-guessing, where nurses balanced clinical judgment against perceived managerial expectations. Interprofessional discrepancies also emerged, particularly in interactions with ambulance personnel. Several nurses expressed frustration that Queensland Ambulance Service (QAS) assessments did not always align with aged-care realities:

"QAS often refuses to transfer to hospital because according to their assessment it's all within normal limits, but we still send them," noted RN (5). With another (RN 8) highlighting assumptions made by paramedic staff that aged-care nurses should possess acute-care competencies: *"I feel they are assuming we have the same level of experience and capability as acute care ward staff and should look after them here."*

These tensions illustrate a broader systemic disconnect between community and acute-care expectations, which undermines collaboration and consistent decision-making.

Theme 3: Clinical Reasoning and Support Structures

This theme captures the variability in clinical reasoning among staff and the stabilising effect of NP involvement. The latent meaning emphasises that decision quality is often contingent on individual reasoning skills and the availability of clinical support.

As one RN (1) observed, *"There is a great variation in both PCW and RN ability in trying to identify resident issues earlier."* Another reflected (RN 6), *"Guidelines have probably helped me to identify and manage issues on an ongoing basis. Yet I feel others have been less astute at recognising a resident's deterioration."*

The inconsistency described here points to the need for structured education and mentorship frameworks.

NPs were identified as key supports that mitigate unnecessary transfers. Participants described NPs as providing clinical reassurance and rapid guidance that helped maintain residents in place.

One RN (7) noted, *"She [referring to the NP] has been there to support us most of the time and we've been able to keep the resident here,"* while another (RN 8) confirmed, *"We might not have our nurse practitioner come every day, but we will still have that contact for decision making."*

This highlights the positive influence of advanced practice roles in building confidence and fostering sound, resident-centred decisions.

Theme 4: PCW Role Clarity and Communication

The final theme concerns ambiguity surrounding PCWs' roles and communication pathways with RNs. The latent meaning centres on how unclear boundaries and communication breakdowns delay early recognition and escalation of resident deterioration. PCWs voiced uncertainty about their scope, with statements such as:

PCW (3) states, "There's a lot of things that we're asked to do that are out of our scope of practice," and PCW (4) expresses, *"I am unclear of where I can go and where the scope of practice stops."*

These uncertainties often created hesitation to act, leaving critical issues unaddressed until escalation was unavoidable. Communication lapses compounded the problem. PCWs described inconsistent handovers and uncertainty about when to alert the RN:

"Five minutes before the start of your shift, you should be in that area getting a handover to better understand residents' needs," PCW (6) advised, while a PCW (2) admitted, *"Even though it's within your scope of practice, I am unclear when to inform the RN."*

Together, these accounts expose how fragmented communication and blurred role definitions compromise timely and effective decision-making within aged-care teams.

DISCUSSION

This study found a clear perception that confidence was low when making decisions among RNs and PCWs regarding hospital transfers, which appeared to stem from clinical reasoning capabilities. Literature identifies several factors influencing nursing confidence, including the level of nursing experience, education and qualifications, organisation and unit culture influences, understanding of patient co-morbidity and history, situation awareness, and clinical reasoning.[17,35]

Findings from this study also suggest that a lack of experience in the RN workforce and unclear guidelines for the PCW workforce may contribute to poor assessment and decision-making when escalating concerns about a resident's health status. Research indicates that when nurses do not use or develop their set skills appropriately to conduct health assessments, this can become an issue. This is because nurses stop applying and developing skills that they can then compromise a resident's healthcare needs and gradually diminish the capability of nursing assessment skills.[36]

While confidence might improve communication and performance in aged care staff, it is not necessarily linked with more effective decision-making.[37] Other researchers have surmised that experienced nurses may not have the time to access evidence-based protocols to facilitate decision-making due to high workload pressure.[31,38] This creates concern as evidence is essential for ideal patient outcomes.[39,40] The quality of nurse decision-making appeared linked to access to timely and appropriate medical assessment.[47,51] It is evident that the decision-making and clinical reasoning skills of the aged care workforce need to keep pace with increasing sub-acute demands. Currently, Australia's health system is under-invested in sub and non-acute care, resulting in care moving to inappropriate places, such as acute hospitals.[41]

 https://doi.org/10.37464/2025.424.1806

Published research has outlined that an RN's decision-making capability and the support offered by GP access are key determinants towards any decision to seek emergency care. Evidence shows that where RACFs have an RN on shift overnight, with close support from regular GPs, they were able to articulate their decision-making processes around seeking hospital transfer more clearly and thereby determine the appropriateness of an ED transfer.[42] As a comparison, voices from participants in this study demonstrated a strong preference for prioritising and advocating for a resident's best outcomes during decision-making around hospital transfer, rather than simply the nature of the acute problem in isolation. This research therefore further supports the findings of Amadoru and colleagues that poor skill mix (staffing levels), knowledge, and decision-making capability, plus limited GP accessibility, are key contributors to potentially avoidable hospital transfers in the Australian context of residential aged cared.[42,43]

The growth of NPs embedded in RACFs has been noted to improve communication with doctors, referred hospital staff, and championed residential aged care staff through capacity building in providing increased sub-acute capabilities on site. It has been suggested by research that advancements in the employment of NPs would galvanise policymakers to approach the aptitude of RNs, interested in becoming NPs, to take the next step in education and training.[42] The Australian Nursing and Midwifery Federation has developed a plan that builds on several reforms for Nurse Practitioners (NPs) announced in the 2023 federal budget, including the removal of longstanding regulatory barriers that have historically restricted NPs from providing the sub-acute services their scope and expertise enable. Moving forward, the federal government will implement a 30% increase in Medicare rebates for NP-led care and introduce new scholarship programs to support and incentivise RNs to upskill as NPs. [43] Strengthening the NP workforce, particularly within aged care, has the potential to enhance timely assessment, stabilisation, and case management in place, thereby reducing unnecessary hospital transfers. Complementing these reforms, the Department of Health and Aged Care now mandates that approved providers must have at least one RN on-site and on duty 24 hours a day, 7 days a week, at each residential facility. [48] Increased RN presence and minimum care-minute requirements may improve clinical capability, support earlier detection of deterioration, and enable more confident decision-making within RACFs, further contributing to the prevention of avoidable ED presentations and hospital admissions.

The role that PCWs play in the assessment, reporting, and monitoring of residents also emerged as a strong theme in this research. The underuse and recognition of PCWs in the early deterioration of a person's health status does appear connected as a contributing factor to escalating hospital transfers. There was evidence of frustration amongst the PCWs interviewed around a breakdown in communication and handover practices, and a response time from the RNs to concerns they had for the resident in their care. Much of the literature supports a role for PCWs in the recognition of a resident's deterioration.[15,16] PCWs constitute about 70% of the aged care workforce and remain unregulated there is a need for improved preparedness using longitudinal and sustained evidence-based education that trains them in the response to a resident's developing deterioration in health.[15,44]

Recent research speaks to an educational mismatch for the PCW workforce, as training frameworks do not adequately develop new care workers contextually for the vital role they play in aged care. Redefining PCW's growing education requirements and scope of practice would therefore appear an essential next step if the aged care sector is to enhance practice, improve the quality of resident care, and minimise unnecessary hospital transfers. Added benefits detailed by recent research include the increasing public confidence that may stem from a more knowledgeable aged care workforce.[16,17] Recommendations stemming from the 2019 Royal Commission into Aged Care identified neglected educational preparedness within the PCW workforce as a major contributor to the systemic issues currently facing the sector. In particular, Recommendation 21 emphasises the need for mandatory professional development, enhanced training, and clear delineation of practice roles and responsibilities.[4] These policy concerns were strongly reflected in the study's findings, which revealed four overarching themes: (1) Clinical Decision-Making and Confidence Under Pressure, (2) Organisational and Interprofessional Dynamics, (3) Clinical Reasoning and Support Structures, and (4) PCW Role Clarity and Communication. Together, these themes demonstrate how gaps in workforce preparation, role understanding, and ongoing capability development continue to shape everyday practice in RACFs, reinforcing the relevance and urgency of the Royal Commission's recommendations.[4]

Decision-making regarding resident transfers to the emergency department is a critical professional responsibility for nurses in RACFs, yet it is often experienced as a constraint due to limited resources, staffing pressures, and medico-legal concerns.[45] These decisions can be ethically complex and risk-averse, sometimes resulting in unnecessary hospital admissions. Strengthening support systems, such as robust outreach programs and in-reach hospital avoidance services, can enhance nurses' confidence and enable care to be delivered safely on-site.[46] Moreover, improving interdisciplinary communication and mutual understanding between aged care nurses, paramedics, and emergency department staff is essential to ensure informed, collaborative decision-making. Shared protocols, telehealth support, and clear goals-of-care documentation can help align clinical actions with resident preferences and reduce avoidable transfers. Empowering aged care nurses through education, clinical governance, and team support is crucial to improving care delivery and resident outcomes.[45,46]

 https://doi.org/10.37464/2025.424.1806

CONCLUSION

This study highlights the complex and multifactorial nature of clinical decision-making regarding hospital transfers from residential aged care settings. Central to the findings is the pivotal role of RNs and their confidence, experience, and clinical reasoning skills in determining whether a resident requires hospitalisation. Variations in experience, particularly among recently graduated RNs, appeared to influence transfer decisions, often prompting transfers that more experienced staff felt might have been avoidable. Compounding this issue is the reported variability in clinical reasoning and the time constraints that hinder thorough assessment, which can lead to rushed or defensive decisions to transfer residents.

The presence of NPs emerged as a valuable support in enhancing RN decision-making, underscoring the importance of advanced clinical roles within aged care teams. However, organisational pressures and scrutiny from management also featured strongly, with both RNs and PCWs citing examples of decisions being second-guessed by leadership, creating an environment of uncertainty and risk aversion.

Furthermore, this study brought forward the significant though often unrecognised role that PCWs play in early detection of deterioration. Many PCWs expressed a lack of clarity around their current scope of practice and voiced a desire for clearer role definitions, improved training, and greater involvement in communication and assessment. Their contributions to monitoring and reporting were seen as essential to the early identification of issues yet inconsistently supported by formal systems and processes.

Ultimately, the findings suggest that a multifaceted approach is required to improve clinical decision-making and reduce potentially avoidable hospital transfers. This includes investment in workforce capability through targeted education and support for RNs, clearer role delineation and training for PCWs, and fostering an organisational culture that promotes interprofessional trust, collaboration, and timely access to medical decision-makers. Addressing these areas could enhance the safety, appropriateness, and timeliness of care provided within aged care settings, minimising unnecessary hospital transfers while supporting staff to act confidently within their clinical roles.

IMPLICATIONS FOR RESEARCH, POLICY, AND PRACTICE

Further studies are needed to explore how RN experience levels affect hospital transfer decisions. Research should evaluate the impact of NPs on decision-making quality and resident outcomes. Further investigation is required on effective models for integrating PCWs into clinical assessment and communication processes. Policy development should focus on supporting structured clinical education and mentorship for RNs, especially early-career nurses. Policies should clarify and formalise the scope of practice for PCWs to enhance their role in early detection and care planning. There needs to be a promotion of staffing models that include NPs to support timely and informed decision-making. By providing targeted training to improve RNs' clinical reasoning and confidence in decision-making standards of practice can only improve.

Acknowledgements: Nil

REFERENCES

1. O'Connell B, Hawkins M, Considine J, Au C. Referrals to hospital emergency departments from residential aged care facilities: stuck in a time warp. *Contemp Nurse.* 2013;45(2):228-33.
2. Chiswell K, Bein K, Simpkins D, Latt M, Dinh M. Emergency department presentations and 30-day mortality in patients from residential aged care facilities. *Aust Health Rev.* 2022;46(4):414-20.
3. Fedele R, Dragon N. ANMF PRIORITIES 2023. (Cover story). *Aust Nurs Midwifery J.* 2023;27(10):8-13.
4. ACQSC. Royal Commission: Final Report: Care, Dignity, and Respect 2023.
5. ANMF. Residents suffer most as aged care crisis deepens. *Aust Nurs Midwifery J.* 2018;25(8):11.
6. ANMF. Relentless, demanding, and unappreciated. *Aust Nurs Midwifery J.* 2018;25(8):10.
7. Munene A, Lang E, Ewa V, Hair H, Cummings G, McLane P, et al. Improving care for residents in long term care facilities experiencing an acute change in health status. *BMC Health Serv Res.* 2020;20(1):1-10.
8. Burke JR, Downey C, Almoudaris AM. Failure to rescue deteriorating patients: a systematic review of root causes and improvement strategies. *J Patient Saf.* 2022;18(1):e140-e55.
9. Wilkinson A, Ressia S, Mowbray PK. The complexities of employee voice within a multiculturally diverse aged care workforce setting. *Asia Pac J Manag.* 2023;61(3):511-34.
10. Scarinci N, Holm A, Torresi K, Sarah W. The complexities of shared decision making in aged care. *J Clin Pract Speech Lang Pathol.* 2022.
11. UARC. Australia's Aged Care Sector Full-Year Report 2023-24. 2024.
12. AIHW. Aged care workforce. 2024. Available from: https://www.gen-agedcaredata.gov.au/topics/aged-care-workforce
13. Bengtsson M, Ekedahl A-BI, Sjöström K. Errors linked to medication management in nursing homes: an interview study. *BMC Nurs.* 2021;20(1):69.
14. Andersson I, Eklund AJ, Nilsson J, Bååth C. Prevalence, type, and reasons for missed nursing care in municipality health care in Sweden – A cross sectional study. *BMC Nurs.* 2022;21(1):95.
15. Martyn J-A, Wilkinson A, Zanella S. Identifying the continuing education needs of personal care workers in two residential aged care facilities by an appreciative inquiry study. *Collegian.* 2022;29(6):887-93.
16. Martyn JA, Zanella S, Wilkinson A. Perspectives from practice: complexities of personal care workers. *Aust Health Rev.* 2019;43(2):238-9.

17. Griffits S, Hines S, Moloney C. Characteristics and processes of registered nurses' clinical reasoning and factors relating to the use of clinical reasoning in practice: a scoping review. *JBI Evid Synth.* 2023;21(4):713-43.
18. Nhongo D, Hendricks J, Bradshaw J, Bail K. Leadership and registered nurses (RNs) working after-hours in Residential Aged Care Facilities (RACFs): A structured literature review. *J Clin Nurs.* 2018;27(21-22):3872-81.
19. ACN ACoN. *The role of nurses in promoting healthy aging.* 2019.
20. Rana R, Gow J, Moloney C, King A, Keijzers G, Beccaria G, et al. Does distance to hospital affect emergency department presentations and hospital length of stay among chronic obstructive pulmonary disease patients? *Intern Med J.* 2022;52(3):403-10.
21. Phillips TM, Moloney C, Sneath E, Beccaria G, Issac H, Mullens AB, et al. Associated factors, assessment, management, and outcomes of patients who present to the emergency department for acute exacerbation of chronic obstructive pulmonary disease: A scoping review. *Respir Med.* 2022;193:106747.
22. Rana R, Gow J, Moloney C, King A, Keijzers G, Beccaria G, et al. Estimating the frequency and cost of emergency department presentations and hospitalisation of chronic obstructive pulmonary disease patients: A retrospective analysis from regional Queensland. *Emerg Med Australas.* 2021;33(3):491-8.
23. Huang Y-L, McGonagle M, Shaw R, Eastham J, Alsaba N, Crilly J. Models of care for frail older persons who present to the emergency department: a scoping review protocol. *System Rev.* 2020;9(1):1-6.
24. Moloney C. Understanding COPD Emergency Department presentations: using thematic analysis to explore the voices of patients, nurses, and doctors on the lived experience of managing COPD. *Aust J Adv Nurs.* 2022;40(1):12-20.
25. RACGP. RACGP aged care clinical guide (Silver Book)2025.
26. Kontos PC, Miller KL, Mitchell GJ. Neglecting the importance of the decision making and care regimes of personal support workers: a critique of standardization of care planning through the RAI/MDS. *Gerontologist.* 2010;50(3):352-62.
27. Epicor. What are the challenges facing aged care in 2025 – beyond legislation? *Australian Aging Agenda.* 2024.
28. Duffield C, Diers D, O'Brien-Pallas L, Aisbett C, Roche M, King M, et al. Nursing staffing, nursing workload, the work environment and patient outcomes. *Appl Nurs Res.* 2011;24(4):244-55.
29. Building Australia's vital aged care Registered Nurse workforce [press release]. 2023.
30. McHugh MD, Aiken LH, Sloane DM, Windsor C, Douglas C, Yates P. Effects of nurse-to-patient ratio legislation on nurse staffing and patient mortality, readmissions, and length of stay: a prospective study in a panel of hospitals. *Lancet.* 2021 May 22;397(10288):1905-1913
31. Aiken LH, Sermeus W, McKee M, Lasater KB, Sloane D, Pogue CA, et al. Physician and nurse well-being, patient safety and recommendations for interventions: cross-sectional survey in hospitals in six European countries. *BMJ Open.* 2024;14(2):e079931.
32. Aiken LH, Sloane DM, Bruyneel L, Van den Heede K, Griffiths P, Busse R, et al. Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study. *Lancet.* 2014;383(9931):1824-30.
33. Meyrick J. What is good qualitative research? A first step towards a comprehensive approach to judging rigour/quality. *J Health Psychol.* 2006;11(5):799-808.
34. Chai CA, Barrios M, Gómez-Benito J, Berrío AI, Guilera G. Information retrieval in face-to-face and online focus groups. A systematic review. *Int J Qual Methods.* 2024;23:16094069241286856.
35. Yamamoto Y, Okuda R, Fukada M. Factors affecting clinical nursing competency: A cross sectional study. *Yonago Acta Med.* 2021;64(1):46-56.
36. Bauer M, Fetherstonhaugh D, Winbolt M. Perceived barriers and enablers to conducting nursing assessments in residential aged care facilities in Victoria, Australia. *Aust J Adv Nurs.* 2018;36(2):14-22.
37. Nibbelink CW, Brewer BB. Decision-making in nursing practice: An integrative literature review. *J Clin Nurs.* 2018;27(5-6):917-28.
38. Dougherty L, Sque M, Crouch R. Decision-making processes used by nurses during intravenous drug preparation and administration. *J Adv Nurs.* 2012;68(6):1302-11.
39. Yancy CW, Jessup M, Bozkurt B, Butler J, Casey DE, Jr., Drazner MH, et al. 2013 ACCF/AHA guideline for the management of heart failure: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. *J Am Coll Cardiol.* 2013;62(16):e147-239.
40. Connor L, Dean J, McNett M, Tydings DM, Shrout A, Gorsuch PF, et al. Evidence-based practice improves patient outcomes and healthcare system return on investment: Findings from a scoping review. *Worldviews Evid Based Nurs.* 2023;20(1):6-15.
41. Dixit SK, Sambasivan M. A review of the Australian healthcare system: A policy perspective. *SAGE Open Med.* 2018;6:2050312118769211.
42. Amadoru S, Rayner J-A, Joseph R, Yates P. Factors influencing decision-making processes for unwell residents in residential aged care: Hospital transfer or Residential InReach referral? *Australas J Ageing.* 2018;37(2):E61-E7.
43. Cappelletti A, Engel JK, Prentice D. Systematic review of clinical judgment and reasoning in nursing. *J Nuse Ed.* 2014;53(8):453-8.
44. Position Statement: Unregulated Health Care Workers. ACN [press release]. 2020.
45. Gurung A, Romeo M, Clark S, Hocking J, Dhollande S, Broadbent M. The enigma: Decision-making to transfer residents to the emergency department; communication and care delivery between emergency department staff and residential aged care facilities' nurses. *Australas J Ageing.* 2022;41(4):e348-e55.
46. Gurung A, Sendall MC, Barnard A. To transfer or not to transfer: Aged care nurses' decision-making in transferring residents to the emergency department. *Collegian.* 2021;28(2):162-70.