Accounting, Auditing & Accountability Journal

Beneficiary evaluation in residential aged care: navigating accountability between rights and care ethics

Kylie L. Kingston and Belinda Luke
School of Accountancy, Queensland University of Technology (QUT), Brisbane, Australia

Received 23 July 2024
Revised 26 September 2025
9 February 2026
16 April 2026
Accepted 20 April 2026

Abstract

Purpose – This research explores how beneficiary-focussed evaluation operates as a mechanism of downward accountability in residential aged care (RAC). We examine the interplay between rights-based frameworks and care ethics, questioning whether Government reforms intended to promote residents' agency translate into meaningful accountability in practice.

Design/methodology/approach – A qualitative case study was conducted in an Australian RAC facility, drawing on interviews with residents, family members, staff and management, as well as observations and document analysis. Residents' experiences of evaluation are interpreted through the theoretical lenses of rights and care ethics.

Findings – Beyond revealing tensions between rights- and care-based logics, findings highlight the limits of rights-based accountability and the challenges of enabling voice in contexts of dependency. Rights-based mechanisms are insufficient where beneficiaries lack the capacity or willingness to claim rights. While relational forms of accountability can support responsiveness, they remain ineffective in the absence of corresponding authority. Accountability mechanisms risk becoming symbolic when expressions of voice are recognised but not translated into response, highlighting responsiveness as fundamental to accountability.

Originality/value – This research advances theory and practice in beneficiary evaluation and downward accountability by proposing a model of accountability that reconceptualises the rights/care relationship in contexts of constrained agency, moving beyond dominant framings of rights and care as distinct forms of accountability. Findings show how residents' affective responses restrict rights enactment in care-based settings, helping to explain why rights-based frameworks weaken when not underpinned by relational, moral and emotional dimensions. The research proposes the potential for an independent intermediary to support the enactment of downward accountability.

Keywords Accountability, Aged care, Beneficiaries, Ethics of care, Older people, Rights

Paper type Research article

1. Introduction

This research is motivated by findings of widespread neglect, abuse and disempowerment of older people in the aged care sector (Cleland *et al.*, 2021; O'Keeffe and David, 2020; Royal Commissions n.d.b), highlighting an urgent need for aged care providers to strengthen accountability towards their key beneficiaries (Chen *et al.*, 2022). This is an international concern (World Health Organization, 2024; Yon *et al.*, 2018), as aged care residents across jurisdictions are noted to have limited individual capacity and a lack of influence (Pérez-Durán and Grimmelikhuijsen, 2024; Wällstedt, 2019).

In response to the Royal Commission review into Aged Care Quality and Safety (hereafter *Royal Commission*), the Australian Government is incorporating a rights-based approach into

Funding: This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Conflict of interest: The authors declare that they have no conflicts of interest.

Accounting, Auditing & Accountability Journal
Vol. 39 No. 9, 2026
pp. 241-265
Emerald Publishing Limited
e-ISSN: 1758-4205
p-ISSN: 1368-0668
DOI 10.1108/AAAJ-07-2024-7252

its revised aged care legislation (Australian Government Department of Health and Aged Care, 2026). Here, a consumer rights focus is complemented by human rights principles of dignity and respect (Grenfell *et al.*, 2021). This approach positions older people as rights-holders entitled to dignity, participation and accountability (Harrison *et al.*, 2023; Siette *et al.*, 2021). However, the literature is unclear on how rights-based approaches to beneficiary participation should be implemented in practice or whether they are effective in achieving their empowerment agendas (Jessop and Peisah, 2021), due to a lack of understanding of what beneficiaries [such as older people living in residential aged care (hereafter *RAC*)] require (Love and Lynch, 2018; Yasmin *et al.*, 2021). Further criticisms of rights-based approaches have been levelled at their pretension of universality and adherence to culturally invariant definitions of human rights (O'Leary and Smith, 2020). Notably, charters of rights are often ineffective in addressing the needs of those excluded (Donnison, 1994), suggesting that an active claim of those rights is required. Therefore, without appropriate structures in place for beneficiaries, particularly those in RAC, to claim their rights, these rights risk remaining symbolic, contributing to false accountability (Sturmberg and Gainsford, 2019).

A key mechanism of accountability is evaluation, including formal feedback processes, audits and surveys (Ebrahim, 2016). However, little is known about how residents in RAC experience these evaluation processes as accountability mechanisms in relation to their rights fulfilment. In RAC contexts, older people often lack confidence and competence (Casado *et al.*, 2020), are frequently excluded from being heard (Petriwskyj *et al.*, 2018), and fear repercussions if they or their advocate (including family members) make a complaint (Cleland *et al.*, 2021; COTA Australia, 2018). These factors suggest that RAC residents are unlikely to be motivated to claim their rights, underscoring the need for careful, sensitive consideration of how these rights can be effectively upheld.

Researchers emphasise that the appropriateness of accountability approaches is context dependent (Agyemang, 2024; Roberts, 2009) (e.g. dealing with powerful versus vulnerable or marginalised stakeholders). While rights-based reforms may strengthen formal accountability structures, supporting instrumental, contractual or rational accountability (Boomsma and O'Dwyer, 2014; Laughlin, 1996; O'Dwyer and Boomsma, 2015), they may dismiss the dimension of accountability that supports a relational responsiveness to the other (Cooper and Johnston, 2012; Favotto *et al.*, 2022; McKernan, 2012; O'Leary *et al.*, 2023; Painter-Morland, 2006; Roberts, 2009; Shearer, 2002). This risks overlooking the affective dimensions of care that shape residents' daily lives, in the aged care context.

Accordingly, this research explores residents' lived experiences of evaluation and accountability in RAC, addressing calls to centre beneficiaries' perspectives in research, and to acknowledge beneficiaries as key stakeholders in organisational decision-making (Benjamin, 2021; Kingston *et al.*, 2023; van Zyl and Claeyé, 2018; Yasmin *et al.*, 2021). We aim to increase understanding of how accountability and evaluation processes can address residents' needs, which are often overlooked in policy and practice (Ibrahim *et al.*, 2020; Sturmberg and Gainsford, 2019). The research question is: *How do aged care residents experience evaluation-focused accountability mechanisms, and how are these experiences shaped by the interplay between rights and care ethics?*

We draw on theoretical perspectives on an ethics of care (Gilligan, 1993; Molterer *et al.*, 2020), which contrast with a rights-based perspective of accountability within non-profit organisations (Chen *et al.*, 2022). An ethics of care (Gilligan, 1993) draws attention to the limits of a rights-based approach, highlighting attentiveness, responsiveness and interconnectedness as essential for understanding how accountability is experienced in practice. In this context, evaluation may act as a bridge between abstract rights and care, enabling a connected form of accounting, or accountability for the other, that fosters empathy (Dellaportas, 2019; Shearer, 2002).

Empirically, the research case studied an Australian RAC facility. The case study involved 18 interviews with residents, family members, care staff and management, as well as regular

onsite visits and observations over an 18-month period, attendance at residents' meetings, and analysis of organisational and regulatory documentation.

By bridging rights-based and care ethics, findings advance understanding of downward accountability in settings where beneficiaries' ability to claim or enact their rights is limited. Findings demonstrate that in the RAC context, formal rights alone cannot ensure residents' agency or empowerment. Here, the gap between residents' formal entitlements and their lived experiences highlights the need for accountability mechanisms in RACs that embed care and responsiveness in evaluation processes, enabling residents' feedback to be both heard and acted upon. Further, we propose the need for an intermediary *evaluative-advocate* to support the enactment of accountability by bridging relational and structural divides between care ethics and rights-based mechanisms.

Beyond revealing tension between rights-based and care-based logics, the findings illuminate the inherent limits of formal accountability processes and the difficulties of enabling meaningful voice in contexts characterised by vulnerability and dependency. The study advances three theoretical contributions to understanding accountability under conditions of constrained agency. First, formal rights-based accountability is insufficient when beneficiaries lack the capacity or willingness to claim their rights. Second, while relational forms of accountability can support responsiveness, they remain ineffective in the absence of support from individuals with corresponding authority to act. Third, accountability mechanisms risk being symbolic when expressions of voice are formally recognised but not translated into organisational responses that have substantive meaning for beneficiaries.

The structure of the paper is as follows. The next section reviews the literature on accountability, rights and care in RAC. This is followed by an explanation of the research approach, data and analysis technique. Section 4 presents the findings as a case study narrative, which is followed by a discussion of the findings in Section 5. The paper concludes by specifying contributions to knowledge and practice, as well as suggestions for further research.

2. Accountability, rights and care in residential aged care

2.1 Accountability to beneficiaries in residential aged care

A key attribute of "downward" accountability towards beneficiary stakeholders (Connolly and Hyndman, 2017; Murtaza, 2012) is its focus on a rights-based approach, positioning beneficiaries as holders of entitlements (O'Dwyer and Unerman, 2010; O'Leary, 2017; Yasmin *et al.*, 2021), contrasting with views that portray beneficiaries as passive recipients of services or interventions (Wellens and Jegers, 2017). As part of organisations' performance management systems (Conaty and Robbins, 2021), evaluation mechanisms such as resident surveys, feedback forms and audits are tools through which accountability may be enacted towards beneficiaries (Berghmans *et al.*, 2017; Ebrahim, 2016). However, managers have expressed concerns that despite the legitimacy of beneficiaries' needs, they typically lack power or salience (Conaty and Robbins, 2021, 2023), suggesting evaluation mechanisms alone may be ineffective in promoting downward accountability and supporting beneficiaries to enact their rights. These perceptions are reflected in deficiencies in the practice of downward accountability, where organisations collect evaluations from beneficiaries but fail to use them in decision-making; instead, primarily serving to satisfy the needs of upward accountability stakeholders, such as funders (O'Dwyer and Unerman, 2010; Yasmin and Ghafran, 2021). Consequently, opportunities for such participation may not achieve the empowerment potential often ascribed to downward accountability (van Zyl and Claeyé, 2018), and may, in practice, leave beneficiaries' perspectives overlooked or unaddressed, and poorly connected to decision-making. This situation highlights the challenge of operationalising rights-based accountability, underscoring the importance of mechanisms that ensure participation and evaluation are responsive, meaningful, acknowledged and can potentially influence organisational processes and outcomes.

Accountability mechanisms in RAC can enable older people to assess the quality of the care they receive (Pérez-Durán and Grimmelikhuijsen, 2024). Here, accountability towards residents may be hierarchical or one-directional, where organisations provide information to residents and their family members (Pérez-Durán and Grimmelikhuijsen, 2024). While supporting transparency, this approach may overlook the relational and socialising dimensions of accountability, leaving evaluation (as a mechanism of accountability) narrowly interpreted as formal inspections or reports (Pérez-Durán and Grimmelikhuijsen, 2024), rather than as opportunities for dialogue, responsiveness and engagement (Brown, 2009; Kelly, 2020; O'Leary *et al.*, 2023). A relational or social (Roberts, 1991) perspective recognises the importance of two-way mechanisms in which stakeholders not only receive information but can also actively participate in evaluation processes, shaping organisational responses. In an RAC context, responsiveness may take multiple forms, including acknowledgement of feedback, action taken in response to concerns (or explanation where action is not taken), and ongoing dialogue and exchange. Recognising responsiveness as integral to accountability shifts understandings away from symbolic resident engagement on the provider's terms towards an embrace of accountability's critical dialogic imperative (Dillard and Vinnari, 2019), where accountability (and responsiveness) on the terms of the other can be prioritised (Kingston *et al.*, 2020). However, hierarchical accountability frameworks typically fail to accommodate this relational dynamic.

Research on RAC accountability during the COVID-19 pandemic revealed the failure of accountability mechanisms to hold providers accountable for the deaths of residents (Graham *et al.*, 2024). Additionally, research has highlighted the privileging of financial priorities and a lack of care, contributing to residents' distress (Twyford, 2023). Furthermore, Wällstedt (2019) explored perspectives of RAC managers and employees, revealing tensions between organisational efficiency and the recognition of residents as individuals. In building upon this growing body of literature, this research contributes residents' perspectives on evaluation processes as a mechanism for accountability.

Researchers have studied aged care providers' practices of accountability towards residents and employees, noting the influence of management on accountability practices (Chen *et al.*, 2022), the funding model within Australian aged care (Twyford *et al.*, 2025) and systems of accountability in outsourced aged care (Hettiarachchi *et al.*, 2024). Despite this prior research, residents' own perspectives on accountability in RAC, including their experiences of care, participation in decision-making and involvement in evaluation processes, remain underexplored (Milte *et al.*, 2016; O'Keeffe and David, 2020; Petriwskyj *et al.*, 2018).

While residents' views on care quality and quality-of-life indicators have been studied (Bowers *et al.*, 2001; Casado *et al.*, 2020; Milte *et al.*, 2016; Petriwskyj *et al.*, 2018; Ratcliffe *et al.*, 2019), little attention has been paid to evaluation as a participatory mechanism of downward accountability in an environment where accountability to residents remains a concern. Understanding how evaluation mechanisms incorporate residents' rights and relational care practices is essential to developing accountability frameworks that reflect the (normative) intentions of government and the ethics embedded in addressing residents' needs. Rights- and care-based perspectives in this context are explored in the following section.

2.2 Exploring accountability from a rights versus care perspective

2.2.1 A rights perspective. In 2018, after a series of high-profile cases of abuse and neglect of older people in aged care contexts were reported in the media, the Australian Government instigated the Royal Commission (Cleland *et al.*, 2021) to investigate the quality and improvement of care within the sector. Upon its conclusion, 148 recommendations were made for generational reform (Hutchens, 2018; Royal Commissions n.d.a). In response to the Royal Commission's recommendations, legislation was introduced to improve accountability and transparency (Aged Care Quality and Safety Commission, 2026), including a new rights-based Act intended to '... put older people who need aged care at the centre of the system'

(Australian Government Department of Health and Aged Care, 2026). Within this framework, older people are positioned as active participants in both their own care and in contributing to the RAC provider. '[T]he provider partners with older people in the design, delivery, evaluation and improvement of quality care and services' (Aged Care Quality and Safety Commission, 2023, p. 12). Additionally, older people should be encouraged and supported to provide feedback and make complaints about the care and services received, and providers are required to collect feedback and review the effectiveness of their complaints system (Australian Government Department of Health and Aged Care, 2023).

While such reforms represent important advances in recognising older people's rights, the rights-based orientation underpinning them risks narrowing accountability to formalised processes of complaints, compliance and system monitoring. Rights discourse privileges abstract principles, universality, fairness, hierarchy and individual entitlements, autonomy and agency (Gilligan, 1993; Reiter, 1997; Rentfro and Hooks, 2006), while struggling to capture the everyday relational dimensions of care (Kingston *et al.*, 2024). In practice, this could result in procedural accountability that responds to systemic requirements, rather than relational accountability responding to the needs of beneficiaries, such as residents in RAC.

Within this rights-based framework, evaluation mechanisms such as feedback systems and complaints processes are positioned as tools for resident participation. However, these mechanisms assume individuals are willing and capable of accessing and enforcing their rights, and may fail to capture the nuanced, affective dimensions of care. Research acknowledges that 'human rights are often not actualized by older people' (Jessop and Peisah, 2021, p. 1), highlighting the importance of understanding older people's ability to claim their rights (Love and Lynch, 2018). Without this understanding, rather than accountability serving the needs of residents in RAC, aged care providers risk engaging in false accountability, where '. . . one applies rule-based processes to situations that are complex and in constant flux . . .' (Sturmberg and Gainsford, 2019, p. 804).

2.2.2 A care-based perspective. Care-based ethics, or an ethics of care (Gilligan, 1993; Tronto, 2013), responds to this inadequacy by critiquing the limitations of applying a solely rights-based view of ethics to organisational governance (Adhariani *et al.*, 2017). The rights-based view emphasises individuality, rules, rights and fairness, mirroring a hierarchical focus of accountability (Roberts, 1991). This perspective contrasts with care-based perspectives on relationships, responsibility, interconnectedness, emotion, plurality, empathy and situatedness (Adhariani *et al.*, 2017; Reiter, 1997). This aligns with notions of accountability to the other (McKernan, 2012; Shearer, 2002) and recognises the importance of a moral responsibility for (Favotto *et al.*, 2022) and responsiveness to (O'Leary *et al.*, 2023) others as inherent to the enactment of accountability.

Importantly, ethics of care values a relational logic (Molterer *et al.*, 2020), emphasising that 'individuals' perceptions and valuation of rights and responsibilities are entangled with and understood through their networks of relationships' (Khan *et al.*, 2023, p. 7). Building on this, Dellaportas (2019) highlights that care ethics is grounded in a relational understanding of the self, in which moral obligations emerge from interdependent networks of need and responsibility, particularly in contexts of vulnerability, acknowledging the importance of being accountable for the other (Shearer, 2002). While care quality has been conceptualised in different ways by RAC residents, e.g. as the provision of a service, as the means of providing comfort, or as relating to and being recognised by others (Bowers *et al.*, 2001), it is consistently viewed as a social practice, enacted in everyday experiences, rather than enforced through a set of rules or charter of rights that define what is good or bad (Molterer *et al.*, 2020). This supports the relevance of a socialising form of accountability (Roberts, 1991) in the aged care context.

Here, the importance of informal dialogue within relationships is recognised (Hill *et al.*, 2001), consistent with a dialogic approach to accountability (Brown, 2009). We contend that a dialogic version of accountability (Dillard and Vinnari, 2019) is inherent to responsiveness (O'Leary *et al.*, 2023) and an ethics of care perspective. However, to move ethics of care beyond a merely optimistic approach, critical scholars have recognised the importance of

including multiple, frequently complex and conflicting stakes and interests (Brown, 2009; Hill *et al.*, 2001). As Cotton *et al.* (2000, p. 6) observe, 'the largely standardized approach of focusing on service targets, patients' complaints and patients' rights may be criticized as misrepresenting what should be in essence a mutual reciprocal relationship of responsibilities'.

The juxtaposition of rights- and care-based approaches highlights an inherent tension. As noted by various researchers (Agyemang, 2024; Roberts, 2009), the context in which accountability is enacted is critical. Accordingly, an approach to accountability that promotes the claiming of rights (consistent with government policy) within a context where care of vulnerable stakeholders is central suggests the need for a relational underpinning. Without this foundation, the promotion of rights may be, at best, unrealistic and, at worst, actively damaging to beneficiaries when those rights cannot be enacted. In an ideal system, logics of rights and care would be mutually reinforcing rather than positioned in competition with one another. However, drawing on the theorised empowerment paradox (Bay-Cheng *et al.*, 2006; Janssen *et al.*, 2014), legislated rights intended to empower residents may have disempowering effects when they prioritise formal participation without sufficient relational or practical support. In practice, rights- and care-based approaches may interact in complex ways, depending on how rights are operationalised and how care is delivered. This highlights the importance of attending to both the formal recognition of rights and their enactment through relational care, particularly in contexts where agency is limited or compromised.

Considering both rights- and care-based approaches enabled us to critically examine the relationship between rights-based policy reforms and residents' care-based needs and experiences, providing a framework to explore how rights intersect with residents' lived experiences. These perspectives informed the analysis and interpretation of data from the case study of a RAC facility, details of which are presented in the following section.

3. The research approach

This research explored residents' experiences of evaluation and accountability in RAC, considering both their rights and the care-based relationships that shape their daily lives. Using a qualitative case study approach, the study examined how opportunities for engagement in evaluation processes reflect principles of an ethics of care, emphasising relationships, responsibility and attention to residents' lived experiences, alongside rights-based considerations such as autonomy, fairness and agency. This approach enabled a nuanced examination of how care-based practices and rights-based mechanisms are represented in, or absent from, evaluation processes, and how they support or limit accountability to residents within a stand-alone, purpose-built RAC facility, referred to as "Resi-care" (pseudonym). We paid particular attention to formal and informal evaluation mechanisms, such as residents' day-to-day conversations with staff, feedback forms and residents' meetings, to understand how these processes supported or hindered residents' ability to influence accountability.

Operated by a nonprofit organisation, Resi-care opened in 2022 in an Australian capital city and provides 24-hour assisted care for approximately 120 residents. Residents have single rooms with en-suites, and the facility includes shared lounges, dining areas, outdoor spaces and a program of lifestyle activities. Residential care is supported by a management team led by a general manager, and by clinical and lifestyle staff.

3.1 Participants and methods

Fieldwork within Resi-care was conducted over 18 months across 2023/24 and included interviews with residents (15), family representatives (2), the general manager (1) and other staff members (2). In addition, observations were enabled through frequent visits and attendance at three Residents and Family Member meetings (hereafter residents' meetings), as

well as analysis of publicly available organisational documentation (e.g. annual reports, websites and brochures) and legislative requirements.

Resi-care accommodates residents with a range of diverse assisted living and cognitive support needs. The residents interviewed in this research were considered by clinical staff to be cognitively capable of engaging in an interview and providing informed consent, noting that cognitive capabilities span a spectrum. Residents with significant cognitive decline, comprising approximately 10% of the Resi-care population, were excluded from the study due to perceived inability to provide informed consent to participate in the research.

Resident participants were recruited through flyers posted within Resi-care. To build trust with residents, the lead researcher spent time at Resi-care, introducing herself to residents and staff and discussing the research objectives. Additionally, the manager introduced the lead researcher and explained the research project at two residents' monthly meetings, where the researcher also responded to any questions. Interested participants approached the researcher to arrange an interview. Following initial interviews, some residents introduced the researcher to additional residents eager to participate in the research, thereby increasing the interview sample. The staff interviewees were purposively sampled to access staff in leadership roles considered able to give an in-depth perspective on residents' evaluative needs, consisting of the aged care manager and the two staff members who lead the clinical and lifestyle divisions. The first interview was conducted with the manager to understand the evaluation and accountability processes used at Resi-care. Subsequent interviews were conducted with residents, family members and the two additional staff members to gain their perspectives on evaluation processes and accountability towards residents. Family members are the spouses of two non-verbal residents who attend the facility daily to assist with their spouse's care. All individuals who expressed interest in participating were interviewed, yielding a final sample of 20. As participation was voluntary, the findings reflect the perspectives of those who self-selected into the research. While this introduces the possibility of non-response bias, the study is qualitative in nature and aims to generate insights rather than make statistically representative claims. Interview questions for residents and staff/management are provided in the appendix. The fieldwork underwent university ethical approval processes prior to commencement. Table 1 provides an overview of the interviews conducted.

As noted in Table 1, most interviews were recorded, and all were conducted face-to-face on-site. Interviews with residents were conducted in the residents' rooms or in quiet areas of communal spaces within Resi-care. Interviews with management and staff members were conducted in their offices or in quiet communal spaces. The majority of interviews were conducted individually; however, on two occasions, residents preferred to be interviewed in small groups. On one occasion, a resident who had been interviewed as part of a small group asked to also be interviewed individually at a later date. Hence, a total of 15 individual residents were interviewed.

The first author also spent time at Resi-care observing situations of informal and formal evaluative activity, e.g. attendance at monthly residents' meetings, informal discussions with residents, family members and care staff, and follow-up discussions with interviewees (see Table 2). These observational and engagement activities added depth and contextual grounding, extending the understandings garnered from the interviews. Additionally, repeated follow-up informal discussions with residents and staff enabled an awareness of change (if any), supporting an in-depth case study of residents' engagement, experiences and perspectives on evaluation and accountability over time. These informal observational engagements examined the relational dimensions of care ethics in practice, enabling a deeper understanding of how trust, attentiveness, and responsiveness shape residents' experiences of accountability.

In addition to this fieldwork, document analysis was conducted of related Australian Government Aged Care legislation, guidance booklets and fact sheets, and website information. Here, the focus was on regulatory and legislative guidelines regarding residents' and providers' involvement in evaluative processes. The emphasis on a rights-

Table 1. Interviewee details

#	Reference code M = manager S = staff R = resident F = family member	Interviewee details	Length
1	M1	Manager (aged care)	85 mins
2	S1	Staff (lead /clinical/nursing)	35 mins
3	S2	Staff (lead activities/lifestyle)	52 mins
4	R1	Resident	75 mins
5	R2.1, R2.2, R2.3	Resident (group x3)	78 mins
6	R3	Resident (same resident as R2.2)	83 mins
7	R4	Resident	52 mins
8	R5	Resident	66 mins
9	R6	Resident	48 mins
10	R7	Resident	40 mins
11	R8	Resident	30 mins
12	F9	Resident's family representative (spouse)	40 mins
13	R10.1, R10.2	Resident (group x2)	35 mins
14	R11	Resident	28 mins
15	R12	Resident	70 mins
16	R13	Resident (not recorded)	35 mins
17	R14	Resident	32 mins
18	F15	Resident's family representative (spouse) (not recorded)	30 mins

Source(s): Authors' own work

Table 2. Case engagement and observations

Duration / frequency	Type of observation or informal data collection activity
1 hour	Orientation visit, on-site with manager
3 occasions	Attendance and observation of the residents' monthly meeting
8 occasions	Regular informal conversations with previous interviewees to discuss and reflect upon any changes (or lack of) that have occurred since the interview. These informal follow-ups occurred each time the lead researcher visited the facility
3 occasions	Informal discussions with the manager about the progress of residents' (consumer) advisory group development (see Section 4.1 for explanation of this group)
2 occasions	Informal discussions with care staff in relation to the research topic

Source(s): Authors' own work

based approach in the initial government documentation reviewed (following the Royal Commission) led to a systematic review of all relevant government and organisational documentation to consider what rights were detailed and how they might be enabled. Further analysis of publicly available organisational documents was conducted, as noted in Table 3.

3.2 Data analysis

Data were thematically analysed with a focus on identifying, analysing, and reporting patterns (themes) (Braun and Clarke, 2006). The phases of thematic analysis were followed, including data familiarisation, code generation and theme identification. This process involved extensive listening to interview recordings and close (re)reading of transcripts (Martinez and Cooper, 2019; Tregidga and Milne, 2020) and other documents, followed by inductive open

Table 3. Documents analysed

Frequency	Documents analysed
3	The parent organisation's annual report: 2021, 2022, 2023
1	Resi-care's website
>15	Australian Government Aged Care legislation and related documents, e.g. acts, guidelines, fact sheets, websites and reports
1	Royal Commission findings

Source(s): Authors' own work

coding and deductive coding to consider theoretical influences of rights- and care-based ethics and key elements from the research question. Here, codes were developed based on the research focus on evaluation mechanisms and accountability. Our iterative analysis of the data produced further codes as analysis progressed, informed by our engagement with ethics of care- and rights-based theories, which assisted in interpreting and explaining the findings.

Discussions amongst coauthors identified commonalities and considered emergent themes, leading to continued abductive analysis during the write-up stage. Abductive analysis enabled awareness of unexpected patterns emerging within the theoretical framework, particularly when residents' experiences departed from policy intentions.

Overarchingly, the findings fell into five broad themes:

(1) Evaluation mechanisms

(2) Context and agency in RAC

(3) Response to the other

(4) Acceptance of limited agency versus advocates for change

(5) Valued care, limited care-based accountability

These themes serve as headings throughout the findings, which are presented in the following case study narrative, where we discuss them in relation to residents' lived experiences of evaluation and accountability in RAC.

4. The case study: residents' lived experiences of evaluation and accountability in RAC

4.1 Evaluation mechanisms

Under Australian legislation, residents in RAC have the right to express opinions, access advocacy and complaints mechanisms, and receive care 'designed to respond to the person's expressed personal needs, aspirations and their preferences' (Royal Commission into Aged Care Quality and Safety, 2021, p. 219). Through a rights-based approach, the Government seeks to empower aged care recipients via the *Statement of Rights*, through assigning powers for the Aged Care Quality and Safety Commissioner to enforce breaches, and by developing new pathways for upholding residents' rights, including the introduction of *Consumer Advisory Bodies* (Harrison *et al*., 2023). Consumer Advisory Bodies, introduced in 2024, are designed to enhance accountability by providing a formal channel for resident committees to provide feedback to the governing body regarding care provision (Aged Care Quality and Safety Commission, 2023).

The Statement of Rights outlines rights for residents accessing aged care services funded by the Australian Government. Stated rights include residents' right to give feedback, complain without fear of being punished, get a quick and fair response to complaints, and to get support from an independent advocate (Aged Care Quality and Safety Commission, 2026). Residents may make complaints to the Commissioner if they believe their rights have not been upheld

(Australian Government Department of Health and Aged Care, 2023, p. 24). Although RAC providers are legally required to implement practices designed to uphold these rights, the onus remains on residents to escalate concerns to the Commissioner if they believe their rights have been violated (Australian Government Department of Health and Aged Care, 2023).

In line with these legislative requirements, Resi-care participates in government accreditation audits. The results of these audits are publicly reported online via star ratings across categories, including *Compliance*, *Staffing*, *Quality Measures and Residents' Experience*, on the Government's My Aged Care website. The 'Residents Experience' rating is of particular relevance for this research and is based on an annual 12-question survey, completed by at least 20% of residents, conducted independently to capture resident perspectives, inform service improvement, and support decision-making by older Australians and their families (Australian Government, 2026).

Within Resi-care, residents can provide feedback through formal internal mechanisms, including written feedback forms located throughout the facility. These forms enable residents or their representatives [including staff (M1, S1)] to submit positive or negative evaluations for management review and consideration. Furthermore, monthly onsite residents' meetings provide a forum for updates from management and staff, as well as opportunities for verbal feedback, suggestions, questions and discussion. Informal evaluation within Resi-care occurs through staff soliciting verbal feedback after events or activities and observing non-verbal responses, such as meal consumption (or lack of) and participation (or lack of) in activities (M1, S1, S2). Residents may additionally contact management directly via face-to-face discussion, email, or telephone.

Although these mechanisms are designed to capture residents' perspectives, they are limited in their capacity to facilitate meaningful engagement due to a perceived lack of responsiveness and dialogue (as discussed in Section 4.3). In practice, the structure of these processes, combined with residents' reliance on care staff and lack of ability or willingness to raise concerns, limits the exercise of agency. These limitations in evaluation mechanisms contribute to a broader sense of disempowerment amongst some residents, as discussed in the following sections.

4.2 Context and agency in RAC

Despite modern facilities, a comfortable environment, and generally positive interactions with staff, many residents described a sense of restriction within RAC, characterising living there as 'like waiting for God' (R12), a transitional space between their previous life and future decline. Residents acknowledged the benefits of RAC, including social contact and support from staff, but often felt limited in their autonomy, describing themselves as 'stuck here' (R2.2, R10.1), especially because, in many cases, their family home was sold to fund their room at Resi-care. These material losses were frequently accompanied by affective responses, including resignation, gratitude (for family support) and reluctance to challenge existing arrangements. Some residents' engagement with the outside world was now often indirect, with windows providing a visual connection to the outside world. 'The world is out there [out the window]' (R5).

Residents discussed their reliance on Resi-care to provide essential services, suggesting that some feel they are subject to Resi-care's decisions and actions regarding those services. For some residents, this results in feelings of despondency and a sense of powerlessness. From a relational perspective, these emotions reflect and reinforce residents' dependence on care providers, shaping how they perceive their ability to question decisions or claim their rights. Here, structural and institutional conditions combined with personal (physical health) limitations highlight a restriction on residents' sense of agency. Such restrictions narrow residents' influence, as their capacity to shape their circumstances is determined more by systemic arrangements than by individual choice. These contextual factors influence residents' perspectives on evaluation and accountability, particularly within a rights-based

approach. The difficult life contexts of some residents, e.g. no longer being able to live independently and care for themselves, highlight their limited agency. This has relevance to the organisation's accountability processes, residents' experience of them, and government policy anchored in rights.

4.3 Response to the other

Residents described using Resi-care's formal feedback mechanisms, such as written feedback forms and participating in the monthly residents-meetings; however, many expressed frustrations that these avenues often resulted in unacknowledged concerns and rarely led to changed outcomes (R2.1, R2.2, R5, R6, R7, R8). Even though staff are encouraged to assist residents who are unable to write to complete the written feedback forms (S1), practical barriers, such as poor eyesight and a lack of confidence with spelling, limited their use. Additionally, family representatives expressed concerns over providing written feedback because complaints might 'fall into the wrong hands' (F15), resulting in adverse repercussions for residents. These concerns were often accompanied by affective responses, including anxiety and reluctance to complain. However, the more common critique of this evaluation mechanism was that feedback was given but not responded to: 'you don't even get a reply from the feedback forms' (R2.1). As a resident summarised, 'we might have a voice, but it may not necessarily get listened to' (R6). Feelings of frustration and resignation emerged where formal opportunities for voice did not translate into response or change. Hence, there was a sense that evaluation mechanisms intended to empower residents were, in practice, disempowering due to a lack of organisational responsiveness.

Despite some residents feeling their written feedback was typically not responded to, staff spoke of the formal systems in place to do so, including a feedback register (M1, S1), monthly reporting of feedback trends to the governing board (S1), and discussions with residents who provide written feedback (S2). Additionally, the manager detailed examples of 'acting' on written feedback and then 'responding' back to the residents (M1). However, while staff noted the difficulty of pleasing every resident (S2), these response processes appear to fall short of residents' expectations of meaningful organisational responsiveness.

Residents' meetings were also seen by some residents as being largely symbolic. While valued as a space for updates and discussion, residents felt that issues raised were seldom followed up on. As one family member noted, 'if we don't do anything about that [issue], in a week's time it'll be forgotten' (F9). The minutes of the residents' meetings, held and recorded by Resi-care staff, were perceived as selective, recording 'all the good news, not the bad news' (R7), creating a sense of a managed rather than authentic engagement and dialogue. Further, some residents disengaged altogether, believing the meetings were too controlled by management (R6).

Discussions on food illustrated this dynamic most clearly. Despite repeated complaints about food quality and variety (e.g. requesting healthier alternatives), management highlighted positive results from the Government's Residents' Experience Survey at a residents' meeting, an evaluation instrument most residents had not been invited to complete (as previously discussed). Some residents felt this juxtaposition discredited their lived experiences and attempts to exercise their rights through providing feedback, eliciting feelings of frustration and discouragement. These responses exemplify the broader problem: opportunities to 'speak' existed, but dialogic opportunities to be genuinely listened to and to have concerns acted upon and responded to appeared less available.

These findings point to accountability gaps: mechanisms for residents to be heard exist but operate symbolically rather than substantively, in the view of some residents. Feedback processes appear to serve organisational legitimacy and record-keeping, while residents' input is not necessarily responded to or translated into action, leaving governance provider-led rather than participatory. For residents, this pattern was associated with feelings of frustration, resignation and diminished trust in formal accountability processes.

Rather than suggesting that accountability in RAC should privilege residents' voices to the exclusion of other stakeholders or forms of expertise, these findings highlight a disconnect between some residents' lived experiences and organisational processes and decision-making, where opportunities to express concerns exist but are often not acknowledged or responded to in a way that meets the needs of residents. While residents may not always be in a position to assess the clinical, financial or legal dimensions of care provisions, their perspectives remain critical to understanding how care is experienced and where accountability processes fail to respond to residents' interests in wellbeing and everyday quality of life.

4.4 Acceptance of limited agency versus advocates for change

While many residents discussed their feelings of frustration at not receiving responses to their feedback, others shared that they did not use the formal feedback forms or speak up at monthly meetings, often due to concerns about being perceived as 'complainers' or fearing negative consequences for their care (R10.1). These concerns illustrate the affective dimensions of accountability, where dependence on care providers shapes residents' emotional judgements about speaking up. Some residents adopted a strategy of submission, preferring to 'go with the flow' (R1), rather than raise issues (R13, R14). While residents acknowledged others' right to advocate for themselves, many of the residents interviewed also refrained from complaining to family members to avoid burdening them or creating tension within their families. Feelings of guilt and responsibility towards family members further constrained residents' willingness to seek support. Some relied on adult children to advocate on their behalf, with varying degrees of success (R6, R7, R13, R14), but others deliberately limited family involvement to prevent family members from feeling guilt or responsibility for having aged parents live in a setting where their agency is limited, and their needs were not addressed (R2.2).

In contrast, a resident without any local family members spoke of relying on a paid professional advocate who speaks on her behalf to the management. To this resident, the advocate was a very important role: 'I mean how many people don't have someone to be able to speak for them!' (R12). The effectiveness of this person in helping the resident navigate the complex aged care system and source a room at Resi-care was emphasised. However, they also used an advocate to raise other issues within Resi-care, highlighting the potential value of an independent third party to assist residents in voicing their concerns, facilitating dialogue and supporting responsiveness.

Staff confirmed that residents are hesitant to make written complaints, particularly when staff members are implicated, noting that residents 'don't want to cause trouble' (S1). Residents also tend to avoid repeating unresolved complaints, reflecting frustration with ineffective feedback channels (S1). Such reluctance underscores how emotional responses to previous non-responsiveness can further disengage residents from accountability mechanisms. Thus, multiple stakeholders and layered accountability relationships emerge in this context, extending beyond mechanisms between the organisation and residents. However, for residents interviewed, frustration centred on the core organisational accountability mechanisms available to them and a perceived lack of responsiveness.

Structural conditions further shape this silence. Limited agency (regarding living independently and selling their family home) and the high demand for aged care services mean many residents feel 'stuck' in their current facility (R10.1). This lack of agency reduces the residents' power to provide feedback or assert their rights, reinforcing the perception that providers face little pressure to act on feedback. 'We're all stuck here because of our health. What are we going to do about it?' (R2.2). This context weakens the rights-based accountability relationship between residents and providers. Further, the lack of responsiveness through existing accountability mechanisms suggests limitations from a care-based perspective. Rather than fostering meaningful relationships characterised by responsiveness and mutual recognition, feedback mechanisms risk reinforcing a symbolic form of governance that structurally and affectively constrains residents' agency. These

dynamics illustrated how accountability mechanisms, when not grounded in relational care, may inadvertently reinforce silence and disengagement, rather than enable dialogic accountability. Here, responsiveness (as determined by residents) emerges as a central mechanism of accountability.

4.5 Valued care, limited care-based accountability

Residents interviewed frequently emphasised the importance of frontline care staff (e.g. registered nurses, lifestyle staff, cleaners and personal carers who assist with daily activities), describing them as 'the best part of this place' (R2.3). However, despite this appreciation, some residents recognised that these staff members hold little authority to address systemic issues, raising concerns about broader accountability mechanisms and management responsiveness. As one resident explained, 'you can tell the [care] staff . . . but they've got no control over it' (R3). Many were also reluctant to burden staff, knowing how busy they were (R2.2, R14). Residents' closeness to care staff, while positive, appeared to produce hesitancy about raising complaints through them, with some residents concerned that passing on complaints could negatively impact these staff's relationships with their employer (R6).

Some residents expressed a desire for more direct and proactive engagement with management. Yet few had been personally invited to provide verbal evaluations, noting that such an invitation would be strongly valued, 'every now and then you have something on your mind . . . you have something that worries you, but you just let it [go]' (R4). Some observed that only more vocal or 'pushy' residents sought out one-to-one discussions with management (R5), raising concerns that quieter residents 'would probably not even speak up' (R12).

Collectively, these accounts highlight a structural accountability gap. Residents' informal everyday relationships with care staff reflect a socialising approach to accountability aligned with care-based ethics of trust and attentiveness. However, those staff members lack the authority to address systemic issues. As a result, while supportive, relational forms of accountability remain limited in their capacity to effect change in the absence of individuals with the corresponding authority to act. At the same time, formal rights-based accountability mechanisms for direct communication with management reflect a more individualising and hierarchical approach to accountability and frequently dissatisfy residents due to partial or non-responsiveness. Consequently, neither care-based nor rights-based pathways alone enable residents to meaningfully influence decisions affecting their lives, often leaving residents marginalised in practice.

5. Discussion

Loneliness, depression, and disengagement are widely recognised as serious mental health concerns within RAC settings (Casey *et al.*, 2016; Tani *et al.*, 2022; Theurer *et al.*, 2015). In this research, residents' disinterest and sense of disempowerment were evident, reflecting not merely individual affective states but also structural and relational constraints embedded in downward accountability mechanisms, particularly in evaluation processes directed at residents in aged care. Residents' appreciation for the care they received was at times contrasted with their experience of accountability, particularly from a rights-based perspective. Many residents interviewed described feeling 'stuck' and unable to change their circumstances, regardless of formal rights or entitlements. As Donnison (1994, p. 23) observes, 'rights are a flimsy weapon for people who have only one landlord to turn to', a sentiment that resonates with some residents' experiences of powerlessness. While residents hold formal rights under the Statement of Rights, their ability and motivation to exercise these rights appear limited. This highlights how accountability is unevenly realised across a spectrum of contractual and communal forms (Laughlin, 1996). In practice, the contractual logic of rights-based accountability is diluted within communal care settings, where relational dependence and everyday interactions shape residents' lived realities.

The disempowerment some residents alluded to was further compounded by a reluctance to engage with evaluation mechanisms. While some residents attempted to raise concerns through feedback forms or meetings, these mechanisms were frequently ineffective. Feedback forms were often disengaging, as some residents were unable to complete them due to physical or cognitive limitations, while several others had previously submitted feedback without observing meaningful changes or receiving any response. This pattern contributed to feelings of futility and disinterest. This lack of response reflects Conaty and Robbins' (2021) finding that, despite being identified as the most important stakeholder group by managers, beneficiaries (such as residents) have very little power to assert their own legitimacy and importance. The contrast between organisational metrics reported through government surveys and the lack of managerial response to some residents' use of internal evaluation mechanisms points to an accountability disconnect and suggests issues may arise when relying on *internal* advocates to represent residents' interests (Conaty and Robbins, 2023), particularly where independence is limited. This highlights the potential for evaluation to become a symbolic procedural requirement rather than an avenue for dialogue that leads to responsiveness and change.

Additionally, positive Government survey outcomes were sometimes used by management to demonstrate general resident satisfaction at residents' meetings, a practice that obscured some residents' concerns and reinforced feelings that their feedback was not taken seriously. When used in this way, the quantification of performance through the Government survey constructed a narrow, selective version of residents' reality (O'Keeffe and David, 2020), where survey results were used as symbols of quality service delivery, effectively turning residents into objects of managerial knowledge (Pflueger, 2016) rather than dialogic participants. Instead of enabling residents' voices to be heard (Australian Government, 2026), the survey became a 'technology of performance' that shaped, monitored and governed residents' actions from a distance (O'Keeffe and David, 2020). Such uses may inadvertently silence alternative or dissenting experiences, particularly those of residents whose concerns fall outside the dominant performance narrative. As with many standardised surveys, limitations arise when they are relied upon in isolation or used for unintended purposes. However, when used alongside dialogic and relational evaluation practices, surveys may complement other accountability practices.

In contrast, most residents valued opportunities for social and personal engagement with those in power, reflecting relational and dialogic forms of accountability (Conaty and Robbins, 2023; Dillard and Vinnari, 2019), particularly where their feedback can be accurately recorded, responded to in ways that align with residents' concerns and acted upon. This may occur at monthly meetings and other forums where residents can express their individual preferences and see them appropriately documented and respected (Boelsma *et al.*, 2014; Milte *et al.*, 2016). Importantly, residents highlighted the limitations of relying on relatives as proxies or advocates for their perspectives. Residents reported that they do not always share their concerns with their adult children, often to avoid burdening them emotionally or practically. This suggests, in contrast to previous research (Pérez-Durán and Grimmelikhuijsen, 2024), that family input, while valuable, cannot be relied upon as a proxy for the resident's perspective. Engaging residents directly, rather than relying on relational proxies, is therefore essential for authentic voice, participatory accountability and meaningful evaluation. However, one resident noted the use of an external advocate as effective, suggesting a potential role for an independent industry representative whom residents can contact if they feel their voices are not being heard, thereby supporting the enactment of accountability when internal mechanisms fail.

Internally, what residents interviewed most strongly called for was the opportunity to individually dialogue with someone who has the authority to potentially effect change, who is independent of the care-staff team, and who can periodically ask them, face-to-face, for verbal feedback. Residents indicated that such engagement would be experienced as more accessible, responsive and meaningful than existing evaluation mechanisms. Such a position may enable a

'creative dialogic interplay and negotiation of complex power relationships to address issues of equity and accountability' (Hill *et al.*, 2001, p. 456).

However, in terms of rights-activation, from the perspective of vulnerable residents in RAC, findings highlight the difficulties they face when claiming their rights and their reliance on 'internal advocates' (Conaty and Robbins, 2023) to represent their voices. These arrangements place residents in a position of mediated voice, in which access to accountability is contingent on others acting on their behalf. Here, the need for a different quality of advocate arises; one that does not place advocacy responsibilities (or burdens) on family members, is not a paid service accessible only to residents who can afford it, and is not embedded within internal organisational processes, where systemic power asymmetries often exist (O'Keeffe and David, 2020; Petriwskyj *et al.*, 2014). In this sense, an *evaluative-advocate* is envisaged as an independent government-funded role, rather than one financed through resident fees or provider budgets, recognising the need to situate such proposals within resource-constrained care systems. The purpose of this role is to enable accountability by facilitating dialogue and ensuring responsiveness that is meaningful to residents and/or others impacted by accountability (e.g. the advocate and family members), as determined by residents themselves. These principles align with care-based perspectives and accountability to the other, grounded in responsiveness (O'Leary *et al.*, 2023).

In practice, this role could be trialled by the Government through the appointment of a modest number of advocates to enable the effectiveness of rights-based principles within the aged care sector. Having an advocate service multiple RAC facilities in a region, both on-site and off-site, offers the benefits of synergy, familiarity with sector-specific concerns and potential solutions for addressing them.

We note the existence of similar advocacy programs often delivered independently by third-party nonprofit organisations supporting the aged care sector. While frequently provided as a free service, the onus is on the resident (or their representative) to contact the advocacy organisation and seek support. As a major point of difference, our research highlights the need for advocates to seek out residents and initiate engagement, thereby reversing the typical *client-service delivery* formula. This change enables residents who typically avoid complaining or seeking advocacy to be included in the evaluation process simply by being asked by the government-supported evaluative-advocate if there is anything they need support with.

We therefore propose a model of accountability that integrates rights-based mechanisms with relational practices of care, trust, and responsiveness, recognising not only residents' formal entitlements but also the affective conditions required for those rights to be exercised. This includes the need for an independent intermediary to support residents in claiming their rights and facilitating accountability in contexts marked by vulnerability, dependence and fear of repercussions. The evaluative-advocate moves away from empowerment discourses embedded in post-factum monologic (complaint) exchanges, in which the responder (provider/manager) holds the power to respond, leaving residents often frustrated, anxious or resigned. Instead, an evaluative-advocate may enable a relational dialogue, supporting accountability exchanges on the residents' terms (Kingston *et al.*, 2020).

If implemented, this role operationalises accountability, not through hierarchical or procedural compliance, but through relational care, acknowledging responsiveness and recognition as central affective mechanisms of accountability. An evaluative-advocate could help to balance rights and care, particularly when residents find it difficult to assert their rights within relationships of dependency. Residents in this research appeared more willing to share concerns with an independent person (i.e. the researcher) than with staff, suggesting that perceptions of independence and emotional neutrality shape willingness to speak. An evaluative-advocate could support residents' feedback by ensuring it is acknowledged, valued and responded to on residents' terms, reducing the risks associated with voicing concerns and bridging the gap between formal rights and actionable accountability, which reflects responsiveness and concern for the other.

As research has suggested, care dialogues transform responsibility from a top-down exercise into a relational, intersubjective process (Abma, 2019; Raghuram *et al.*, 2009; Schuchter and Heller, 2018) grounded in empathy and recognition. An evaluative-advocate role illustrates how rights can be operationalised from the bottom up, within a logic of care that takes residents' emotional experiences seriously. This role enables accountability to be enacted through dialogue, trust and responsiveness (Favotto *et al.*, 2022; O'Leary *et al.*, 2023), qualities that emerge in this research as particularly salient in contexts where individuals' agency is constrained. In the absence of an evaluative-advocate, accountability in this setting risks remaining merely symbolic, formalised through compliance practices rather than realised through substantively responsive action that residents experience as meaningful, legitimate, and caring (Dillard and Vinnari, 2019; Li and McKernan, 2016).

Market-based models of aged care also shape evaluation practices, privileging quantifiable satisfaction metrics over relational feedback, which further distances some residents from meaningful participation. Residents are positioned as consumers, assumed capable of exercising choice and moving between providers if dissatisfied (Chen *et al.*, 2022; O'Keeffe and David, 2020). In practice, however, agency constraints, workforce shortages and physical or cognitive limitations severely restrict such consumer agency. Walker *et al.* (2022, p. e302) note that 'care is not a commodity to be freely traded on the market, but an intimate act that requires trust, attention and relationship'. Rights framed as market entitlements risk being illusory in this context, reinforcing structural power imbalances rather than enabling genuine agency (Andrew, 1986; Donnison, 1994; Kingston *et al.*, 2024).

In returning to the research question: *How do aged care residents experience evaluation-focused accountability mechanisms, and how are these experiences shaped by the interplay between rights and care ethics?*, collectively, these findings indicate that the existence of formalised rights-based frameworks, while valuable, is insufficient to facilitate accountability in practice, particularly in environments where beneficiaries are disempowered, marginalised, unheard or lack a sense of agency or emotional safety (Agyemang, 2024). Residents and beneficiaries in marginalised situations more broadly may be better supported when accountability is enabled by relational, care-based practices that acknowledge vulnerability, dependence and the affective conditions under which people are willing and able to speak, rather than relying on post-factum complaints, impersonal surveys or proxy reporting.

The evaluative-advocate offers a potential mechanism through which rights may be operationalised within an ethics of care, translating formal entitlements into actionable, relationally grounded accountability (Scobie *et al.*, 2023). By embedding trust, attentiveness, responsiveness and dialogue at the heart of evaluation and decision-making, this approach creates conditions in which residents feel heard, taken seriously and supported to raise concerns without fear of negative repercussions. In doing so, it helps bridge the gap between formal recognition of rights and individuals'/residents' lived experiences of care in RAC contexts. These findings respond directly to the research question by illustrating how evaluation-based accountability mechanisms are experienced through the lens of both rights and care ethics, revealing not only structural limitations of current practices but also the central role of affect, relationships and responsiveness in shaping whether accountability is enacted or remains symbolic.

6. Conclusion

Findings from this research emphasise that for downward accountability to be enacted, it must go beyond the collection of beneficiaries' feedback, to ensuring that feedback is responded to (on beneficiaries' terms) and acted upon, with beneficiaries' voices respected and embedded in care practices (Milte *et al.*, 2016). The research draws attention to the power imbalance older people feel within RAC contexts (Casado *et al.*, 2020; Petriwskyj *et al.*, 2014), which, if left unaddressed, can lead some older people to withdraw from evaluative opportunities and actively silence themselves (Casado *et al.*, 2020).

The research bridges rights-based and care ethics frameworks in contexts where beneficiaries have a limited ability to claim or exercise their rights. Findings support reconsidering care-based accountability as a fundamental principle across contexts where individuals feel vulnerable and dependent, with limited agency or power. While prior studies have critiqued the limitations of rights-based approaches in empowering beneficiaries (Yasmin *et al.*, 2021), this study demonstrates that, in the context of aged care, formal entitlements alone are insufficient to enable beneficiaries' agency, and that rights are meaningless for those without the agency or willingness to exercise those rights, and thus rely on being accessed through relational engagement, grounded in trust and responsiveness (Gilligan, 1993; Molterer *et al.*, 2020; O'Leary *et al.*, 2023; Tronto, 2013). Downward accountability is therefore enacted when responsive, relational and dialogic principles are embedded in both formal accountability mechanisms and everyday care practices. Rather than being moral or ethical embellishments, these are the very means by which accountability is rendered meaningful in this context.

Residents' affective responses, such as gratitude, guilt and reluctance to be perceived as demanding, appear to play a central role in shaping how accountability is enacted in care contexts. Emerging within relationships of dependence and asymmetrical power, these affective responses influence residents' willingness to claim rights or voice concerns, often constraining accountability in practice. Recognising these affective dynamics helps explain why rights-based frameworks weaken when they are not grounded in relational conditions that acknowledge the moral, (inter)personal and emotional dimensions of care, underpinned by a genuine engagement with and responsiveness to the other.

Echoing critiques of symbolic accountability (Boomsma and O'Dwyer, 2014; O'Dwyer and Unerman, 2010; Sturmberg and Gainsford, 2019), this study shows how evaluation mechanisms, such as feedback forms and surveys, tend to prioritise accountability and organisational legitimacy upward, over resident or beneficiary agency. These mechanisms, when enacted in contexts of structural constraints and relational hesitancy, reproduce an empowerment paradox (Bay-Cheng *et al.*, 2006; Janssen *et al.*, 2014), in which practices intended to support voice and participation instead contribute to disempowerment, disengagement and largely symbolic forms of procedural evaluation.

Findings from this research highlight the potential value of an *evaluative-advocate* as an external relational intermediary who supports residents in expressing concerns and navigating accountability processes (Conaty and Robbins, 2023). This is particularly relevant in contexts of dependency and vulnerability, so beneficiaries can access their intended rights. This builds on calls for relational accountability (Abma and Widdershoven, 2014; Conaty and Robbins, 2023; Roberts, 1991) and connected accounting (Dellaportas, 2019) and responds to concerns of market-based models that position care as a commodity (Walker *et al.*, 2022). Further, this role offers the potential to address beneficiaries' lack of power to assert their legitimacy and importance in organisational contexts (Conaty and Robbins, 2021). Here, the evaluative-advocate can support residents to realise, access and express their power, ensuring downward accountability processes reflect and respect beneficiary voice, and enhance beneficiaries' salience (Conaty and Robbins, 2021). The evaluative-advocate enables the enactment of accountability by bridging relational and structural divides (between care ethics and rights-based mechanisms), supporting beneficiaries (or residents in the RAC context) to be heard and to influence decisions that affect their daily lives.

Further, findings challenge the adequacy of relying on family members as proxies to represent residents' perspectives, a practice often assumed in aged care policy and evaluation (Pérez-Durán and Grimmelikhuijsen, 2024). As noted in prior research, residents are frequently excluded from direct participation, with accountability mechanisms often directed towards family members rather than residents themselves (Pérez-Durán and Grimmelikhuijsen, 2024; Petriwskyj *et al.*, 2018). However, this study found that residents may deliberately limit disclosure to or involvement of family members to avoid burdening relatives or creating tension, and that proxy advocacy is inconsistent and sometimes

ineffective. These findings reinforce critiques that proxy-based approaches risk misrepresenting older people's lived experiences and preferences (Cleland *et al.*, 2021; COTA Australia, 2018). The proposed evaluative-advocate addresses this gap by enabling residents to provide face-to-face feedback to an independent third party, facilitated, for example, by a government or other externally supported program. This intermediary role may be of benefit in broader nonprofit contexts, ensuring beneficiaries' voices are authentically heard and acted upon across the sector. While formal accountability regimes are important structures, they often require relational mechanisms to enact accountability, underpinned by care and concern for the other.

This study, therefore, makes three related theoretical contributions to progress knowledge on accountability in contexts of vulnerability and dependency. First, the research advances understanding of the limits of rights-based accountability by showing that formal mechanisms premised on autonomous rights-claiming are insufficient where beneficiaries lack the capacity or willingness to claim those rights. Second, the study contributes to theorising relational accountability by demonstrating that, while relational forms can enable voice and response, they lack efficacy in the absence of actors/individuals with the corresponding authority to act. Third, the research extends understanding of accountability and voice by conceptualising how accountability mechanisms may become symbolic when expressions of voice are not translated into responsiveness, thereby disconnecting participation from meaningful consequence.

We acknowledge that the statistical generalisability of these findings is limited by the in-depth single-case study design and self-selected sample of a small number of participants from one organisation. However, the findings support theoretical generalisation and encourage further research to explore how evaluative-advocates might be implemented, including understanding their forms, activities and potential applications across the nonprofit sector. Areas for future research include engaging with a wider range of cases and stakeholder groups, including policymakers, boards and peak bodies, to understand how strategies such as the evaluative-advocate might function in practice. Embedding such relational mechanisms into policy and practice could transform accountability from a procedural obligation into a lived reality for beneficiaries, embedded in relationships.

Acknowledgments

The authors thank Professor Parker and the anonymous journal peer reviewers for their constructive and insightful feedback, which has strengthened this paper immeasurably. We also acknowledge the valuable comments provided by participants at the ACSEAR conference, University of Canterbury in 2024, especially discussant Dr Erin Twyford and participants at the ISTR conference, University of Antwerp in 2024. And most importantly, we thank the residents, staff and RAC organisation for sharing their valuable insights and participating in this research.

Appendix

Semi-structured interview questions:

Resident/family interview protocol:

(1) How long have you been involved with _ [organisation]?

(2) What types of services are you involved with at _ [organisation]?

(3) I am interested in your thoughts on evaluating services you receive, but I wonder what evaluation means to you?

(4) Do you let the organisation know how you are feeling about the service/s you receive? If so, how?

(5) Does anyone at [the organisation] ask you how you feel about the service you receive? If so, how do they ask you?

(6) [If yes to 4] Did you notice how (or if) [the organisation] used the information you told them?

(7) I am particularly interested in ways that you might be communicating evaluatively to [the organisation], even without thinking of it as an evaluation. Are there other ways that you communicate evaluations to [the organisation]? Maybe ways you have thought of yourself?

(8) Do you think it is important to evaluate the service you receive?

(9) Are there other ways you would like to evaluate the service you receive?

(10) Are there ways you evaluate that don't involve verbal or written communication? What are they?

(11) Are there any other parts of [the organisation] that you would like to evaluate other than the actual service/s you receive?

Staff/Management interview protocol:

(1) Can you please describe your position within [organisation] and how long you have been doing that?

(2) What type of service/s does your organisation provide?

(3) Do residents participate in formally evaluating the organisation? If so, can you tell me about that process, how it works, its benefits, drawbacks, etc.? If not, is it something that you think might be of value, why/why not?

(4) I am particularly interested in how residents might be communicating evaluatively – even if they aren't thinking of them as evaluations. Have you observed ways that beneficiaries are evaluating the service/s informally – ways they have thought of or developed themselves?

(5) Do you think residents want to evaluate the service/s? Why, why not?

(6) What would be the aim of residents evaluating residential aged care facilities?

(7) What do you think is important to know about the residents' experience at the organisation?

(8) How does/could the organisation use information provided by residents in an evaluation?

(9) Have you observed, or can you think of, any negative implications of residents evaluating the organisation?

(10) Are there barriers to residents being involved in evaluation processes? For example, time, tools and skills.

References

Abma, T.A. (2019), "Dialogue and deliberation: new approaches to including patients in setting health and healthcare research agendas", *Action Research*, Vol. 17 No. 4, pp. 429-450, doi: 10.1177/1476750318757850.

Abma, T. and Widdershoven, G. (2014), "Dialogical ethics and responsive evaluation as a framework for patient participation", *American Journal of Bioethics*, Vol. 14 No. 6, pp. 27-29, doi: 10.1080/15265161.2014.900143.

Adhariani, D., Sciulli, N. and Clift, R. (2017), "An introduction to the ethics of care", in Adhariani, D., Sciulli, N. and Clift, R. (Eds), *Financial Management and Corporate Governance from the Feminist Ethics of Care Perspective*, Springer International Publishing, Cham, pp. 17-48, doi: 10.1007/978-3-319-33518-6_2.

Aged Care Quality and Safety Commission (2023), "Consumer advisory body – fact sheet", Commonwealth of Australia, available at: https://www.agedcarequality.gov.au/resource-library/consumer-advisory-body-fact-sheet

Aged Care Quality and Safety Commission (2023), "Strengthened aged care quality standards. Final draft", Commonwealth of Australia, available at: https://www.health.gov.au/resources/publications/the-strengthened-aged-care-quality-standards-final-draft

Aged Care Quality and Safety Commission (2026). "Guidance and resources – introduction", Commonwealth of Australia, available at: https://www.agedcarequality.gov.au/media/80037

Aged Care Quality and Safety Commission (2026), "Statement of Rights", Commonwealth of Australia, available at: https://www.agedcarequality.gov.au/older-people/your-rights/statement-rights

Agyemang, G. (2024), "Let's have a relook at accountability", *The British Accounting Review*, Vol. 56 No. 1, 101262, doi: 10.1016/j.bar.2023.101262.

Andrew, E. (1986), "Weil,Simone on the injustice of rights-based doctrines", *Review of Politics*, Vol. 48 No. 1, pp. 60-91, doi: 10.1017/S0034670500037517.

Australian Government Department of Health and Aged Care (2026), "About the new aged care act", available at: https://www.health.gov.au/our-work/aged-care-act/about

Australian Government Department of Health and Aged Care (2026), "A rights-based new aged care act", available at: https://www.health.gov.au/our-work/aged-care-act/rights

Australian Government (2026), "What residents think about aged care", *My Aged Care*, available at: https://www.myagedcare.gov.au/what-residents-think

Australian Government Department of Health and Aged Care (2023), "A new aged care act: exposure draft", Consultation paper No. 2, available at: https://www.health.gov.au/resources/publications/a-new-aged-care-act-exposure-draft-consultation-paper-no-2

Bay-Cheng, L.Y., Lewis, A.E., Stewart, A.J. and Malley, J.E. (2006), "Disciplining 'Girl talk' the paradox of empowerment in a feminist mentorship program", *Journal of Human Behavior in the Social Environment*, Vol. 13 No. 2, pp. 73-92, doi: 10.1300/j137v13n02_05.

Benjamin, L.M. (2021), "Beyond programs: toward a fuller picture of beneficiaries in nonprofit evaluation", in *A Research Agenda for Evaluation*, Edward Elgar Publishing, pp. 81-103.

Berghmans, M., Simons, M. and Vandenabeele, J. (2017), "What is negotiated in negotiated accountability? The case of INGOs", *Voluntas: International Journal of Voluntary and Nonprofit Organizations*, Vol. 28 No. 4, pp. 1529-1561, doi: 10.1007/s11266-016-9759-3.

Boelsma, F., Baur, V.E., Woelders, S. and Abma, T.A. (2014), "'Small' things matter: residents' involvement in practice improvements in long-term care facilities", *Journal of Aging Studies*, Vol. 31, pp. 45-53, doi: 10.1016/j.jaging.2014.08.003.

Boomsma, R. and O'Dwyer, B. (2014), "The nature of NGO accountability: conceptions, motives, forms and mechanisms", in Bebbington, J., Unerman, J. and O'Dwyer, B. (Eds), *Sustainability Accounting and Accountability*, Routledge, New York, pp. 175-193.

Bowers, B.J., Fibich, B and Jacobson, N. (2001), "Care-as-service, care-as-relating, care-as-comfort: understanding nursing home residents' definitions of quality", *The Gerontologist*, Vol. 41 No. 4, pp. 539-545, doi: 10.1093/geront/41.4.539.

Braun, V. and Clarke, V. (2006), "Using thematic analysis in psychology", *Qualitative Research in Psychology*, Vol. 3 No. 2, pp. 77-101, doi: 10.1191/1478088706qp063oa.

Brown, J. (2009), "Democracy, sustainability and dialogic accounting technologies: taking pluralism seriously", *Critical Perspectives on Accounting*, Vol. 20 No. 3, pp. 313-342, doi: 10.1016/j.cpa.2008.08.002.

Casado, T., Sousa, L. and Touza, C. (2020), "Older people's perspective about their participation in health care and social care services: a systematic review", *Journal of Gerontological Social Work*, Vol. 63 No. 8, pp. 878-892, doi: 10.1080/01634372.2020.1816591.

Casey, A.-N.S., Low, L.-F., Jeon, Y.-H. and Brodaty, H. (2016), "Residents perceptions of friendship and positive social networks within a nursing home", *The Gerontologist*, Vol. 56 No. 5, pp. 855-867, doi: 10.1093/geront/gnv146.

Chen, J., Harrison, G. and Jiao, Lu (2022), "Rights-based accountability in aged care organisations: the roles of beliefs and boundary controls", *Australian Journal of Public Administration*, Vol. 81 No. 3, pp. 492-511, doi: 10.1111/1467-8500.12538.

Cleland, J., Hutchinson, C., Khadka, J., Milte, R. and Ratcliffe, J. (2021), "What defines quality of care for older people in aged care? A comprehensive literature review", *Geriatrics and Gerontology International*, Vol. 21 No. 9, pp. 765-778, doi: 10.1111/ggi.14231.

Conaty, F. and Robbins, G. (2021), "A stakeholder salience perspective on performance and management control systems in non-profit organisations", *Critical Perspectives on Accounting*, Vol. 80, 102052, doi: 10.1016/j.cpa.2018.07.001.

Conaty, F. and Robbins, G. (2023), "Accountability logics in disability service NPOs – incorporating the role of service user advocacy in accountability and management control systems", *Accounting, Auditing and Accountability Journal*, Vol. 36 No. 4, pp. 1110-1136, doi: 10.1108/AAAJ-08-2021-5395.

Connolly, C. and Hyndman, N. (2017), "The donor–beneficiary charity accountability paradox: a tale of two stakeholders", *Public Money and Management*, Vol. 37 No. 3, pp. 157-164, doi: 10.1080/09540962.2017.1281629.

Cooper, C. and Johnston, J. (2012), "Vulgate accountability: insights from the field of football", *Accounting, Auditing and Accountability Journal*, Vol. 25 No. 4, pp. 602-634, doi: 10.1108/09513571211225060 (accessed 8 September 2025).

COTA Australia (2018), "Project report: measuring quality and consumer choice in aged care", available at: https://policycommons.net/artifacts/3686815/project-report/4492734/

Cotton, P., Fraser, I.A.M. and Hill, W.Y. (2000), "The social audit agenda—primary health care in a stakeholder society", *International Journal of Auditing*, Vol. 4 No. 1, pp. 3-28, doi: 10.1111/1099-1123.00301.

Dellaportas, S. (2019), "The role of accounting in mediating empathic care for the 'other'", *Accounting, Auditing and Accountability Journal*, Vol. 32 No. 6, pp. 1617-1635, doi: 10.1108/AAAJ-02-2017-2860 (accessed 4 2022 September).

Dillard, J. and Vinnari, E. (2019), "Critical dialogical accountability: from accounting-based accountability to accountability-based accounting", *Critical Perspectives on Accounting*, Vol. 62, pp. 16-38, doi: 10.1016/j.cpa.2018.10.003.

Donnison, D.V. (1994), "Chapter 3: What can be done at a local scale?", *Act Local: Social Justice from the Bottom up*, Institute for Public Policy Research, London, Vol. 13.

Ebrahim, A. (2016), "The many faces of nonprofit accountability", in Renz, D.O. and Herman, R.D. (Eds), *The Jossey-Bass Handbook of Nonprofit Leadership and Management*, Wiley, New Jersey.

Favotto, A., McKernan, J.F. and Zou, Y. (2022), "Speculative accountability for animal kinship", *Critical Perspectives on Accounting*, Vol. 84, 102360, doi: 10.1016/j.cpa.2021.102360.

Gilligan, C. (1993), *In a Different Voice: Psychological Theory and Women's Development*, Harvard University Press, Cambridge.

Graham, C., Himick, D. and Nappert, P.-L. (2024), "The dissipation of corporate accountability: deaths of the elderly in for-profit care homes during the coronavirus pandemic", *Critical Perspectives on Accounting*, Vol. 99, 102595, doi: 10.1016/j.cpa.2023.102595.

Grenfell, L., Mackay, A. and Debeljak, J. (2021), "Human rights accountability for systems of ill-treatment in residential aged care", *Monash UL Rev*, Vol. 47 No. 3, pp. 57-113.

Harrison, G., Chen, J. and Jiao, Lu (2023), "Transformational leadership style and holistic accountability mechanisms in not-for-profit organisations", *Accounting and Business Research*, Vol. 55 No. 2, pp. 1-27, doi: 10.1080/00014788.2023.2277919.

Hettiarachchi, D.C., Mihret, D., Subramaniam, N. and Jalathge, S.L.U. (2024), "Accountability in outsourced public service delivery: an Australian study", *Public Management Review*, Vol. 27 No. 12, pp. 1-22, doi: 10.1080/14719037.2024.2372450.

Hill, W.Y., Fraser, I. and Cotton, P. (2001), "On patients' interests and accountability: reflecting on some dilemmas in social audit in primary health care", *Critical Perspectives on Accounting*, Vol. 12 No. 4, pp. 453-469, doi: 10.1006/cpac.2000.0436.

Hutchens, G. (2018), "Scott Morrison announces royal commission into aged care after string of scandals", *The Guardian*, available at: https://www.theguardian.com/australia-news/2018/sep/16/morrison-to-announce-royal-commission-into-aged-care-after-string-of-scandals (accessed August, 2022).

Ibrahim, J.E., Fetherstonhaugh, D., Rayner, J.-A., McAuliffe, L., Jain, B. and Bauer, M. (2020), "Meeting the needs of older people living in Australian residential aged care: a new conceptual model", *Australasian Journal on Ageing*, Vol. 39 No. 2, pp. 148-155, doi: 10.1111/ajag.12796.

Janssen, B., Abma, T.A. and Regenmortel, T.V. (2014), "Paradoxes in the care of older people in the community: walking a tightrope", *Ethics and Social Welfare*, Vol. 8 No. 1, pp. 39-56, doi: 10.1080/17496535.2013.776092.

Jessop, T. and Peisah, C. (2021), "Human rights and empowerment in aged care: restraint, consent and dying with dignity", *International Journal of Environmental Research and Public Health*, Vol. 18 No. 15, p. 7899, doi: 10.3390/ijerph18157899, available at: https://www.mdpi.com/1660-4601/18/15/7899

Kelly, L.M. (2020), *Evaluation in Small Development Non-Profits : Deadends, Victories and Alternative Routes*, Springer International Publishing AG, Cham, available at: http://ebookcentral.proquest.com/lib/qut/detail.action?docID=6382155

Khan, M.H., Williams, J., Williams, P. and Mayes, R. (2023), "Caring in the gig economy: a relational perspective of decent work", *Work, Employment and Society*, Vol. 38 No. 4, 1127, doi: 10.1177/09500170231173586.

Kingston, K.L., Craig, F., de Zwaan, L. and Alderman, L. (2020), "From monologic to dialogic: accountability of nonprofit organisations on beneficiaries' terms", *Accounting, Auditing and Accountability Journal*, Vol. 33 No. 2, pp. 447-471, doi: 10.1108/aaaj-01-2019-3847.

Kingston, K.L., Craig, F., de Zwaan, L. and Alderman, L. (2023), "Avoiding the accountability 'sham-ritual': an agonistic approach to beneficiaries' participation in evaluation within nonprofit organisations", *Critical Perspectives on Accounting*, Vol. 92, 102261, doi: 10.1016/j.cpa.2020.102261.

Kingston, K.L., Rossi, S., Luke, B. and Williamson, A. (2024), "Authentic beneficiary engagement in the aged care sector: advancing nonprofit governance through care", in Plaisance, G. and Belghit, A.G. (Eds), *Non-Profit Governance: Twelve Frameworks for Organizations and Research*, Routledge, available at: https://www.routledge.com/Non-profit-Governance-Twelve-Frameworks-for-Organisations-and-Research/Plaisance-GoujonBelghit/p/book/9781032599861

Laughlin, R. (1996), "Principals and higher principals: accounting for accountability in the caring professions", in Munro, I. and Mouritsen, J. (Eds), *Accountability: Power, Ethos and the Technologies of Managing*, International Thomson Business Press, London, pp. 225-244.

Li, Y. and McKernan, J. (2016), "Human rights, accounting and the dialectic of equality and inequality", *Accounting, Auditing and Accountability Journal*, Vol. 29 No. 4, pp. 568-593, doi: 10.1108/AAAJ-07-2015-2142.

Love, J.G. and Lynch, R. (2018), "Enablement and positive ageing: a human rights-based approach to older people and changing demographics", *International Journal of Human Rights*, Vol. 22 No. 1, pp. 90-107, doi: 10.1080/13642987.2017.1390310.

Martinez, D.E. and Cooper, D.J. (2019), "Assembling performance measurement through engagement", *Accounting, Organizations and Society*, Vol. 78, 101052, doi: 10.1016/j.aos.2019.04.002.

McKernan, J.F. (2012), "Accountability as aporia, testimony and gift", *Critical Perspectives on Accounting*, Vol. 23 No. 3, pp. 258-278, doi: 10.1016/j.cpa.2011.12.009.

Milte, R., Shulver, W., Killington, M., Bradley, C., Ratcliffe, J. and Crotty, M. (2016), "Quality in residential care from the perspective of people living with dementia: the importance of personhood", *Archives of Gerontology and Geriatrics*, Vol. 63, pp. 9-17, doi: 10.1016/j.archger.2015.11.007.

Molterer, K., Hoyer, P. and Steyaert, C. (2020), "A practical ethics of care: tinkering with different 'Goods' in residential nursing homes", *Journal of Business Ethics*, Vol. 165 No. 1, pp. 95-111, doi: 10.1007/s10551-018-04099-z.

Murtaza, N. (2012), "Putting the lasts first: the case for community-focused and peer-managed NGO accountability mechanisms", *Voluntas: International Journal of Voluntary and Nonprofit Organizations*, Vol. 23 No. 1, pp. 109-125, doi: 10.1007/s11266-011-9181-9.

O'Dwyer, B. and Boomsma, R. (2015), "The co-construction of NGO accountability", *Accounting, Auditing and Accountability Journal*, Vol. 28 No. 1, pp. 36-68, doi: 10.1108/AAAJ-10-2013-1488.

O'Dwyer, B. and Unerman, J. (2010), "Enhancing the role of accountability in promoting the rights of beneficiaries of development NGOs", *Accounting and Business Research*, Vol. 40 No. 5, pp. 451-471, doi: 10.1080/00014788.2010.9995323.

O'Keeffe, P. and David, C. (2020), "Discursive constructions of consumer choice, performance measurement and the marketisation of disability services and aged care in Australia", *Australian Journal of Social Issues*, Vol. 57 No. 4, pp. 938-955, doi: 10.1002/ajs4.139.

O'Leary, S. (2017), "Grassroots accountability promises in rights-based approaches to development: the role of transformative monitoring and evaluation in NGOs", *Accounting, Organizations and Society*, Vol. 63, pp. 21-41, doi: 10.1016/j.aos.2016.06.002.

O'Leary, S. and Smith, D. (2020), "Moments of resistance: an internally persuasive view of performance and impact reports in non-governmental organizations", *Accounting, Organizations and Society*, Vol. 85, 101140, doi: 10.1016/j.aos.2020.101140.

O'Leary, S., Dinh, T. and Frueh, S. (2023), "Affirmative otherness in a humanitarian NGO: implications for accountability as responsiveness", *Accounting, Organizations and Society*, Vol. 111, 101495, doi: 10.1016/j.aos.2023.101495.

Painter-Morland, M. (2006), "Redefining accountability as relational responsiveness", *Journal of Business Ethics*, Vol. 66 No. 1, pp. 89-98, doi: 10.1007/s10551-006-9046-0.

Pérez-Durán, I. and Grimmelikhuijsen, S. (2024), "Watching care behind closed doors: upward and downward accountability mechanisms in nursing home services", *Public Management Review*, Vol. 27 No. 5, pp. 1-20, doi: 10.1080/14719037.2024.2402351.

Petriwskyj, A., Gibson, A. and Webby, G. (2014), "Participation and power in care: exploring the 'client' in client engagement", *Journal of Aging Studies*, Vol. 31, pp. 119-131, doi: 10.1016/j.jaging.2014.09.007.

Petriwskyj, A., Gibson, A. and Webby, G. (2018), "What does client 'engagement' mean in aged care? An analysis of practice", *Ageing and Society*, Vol. 38 No. 7, pp. 1350-1376, doi: 10.1017/S0144686X17000095.

Pflueger, D. (2016), "Knowing patients: the customer survey and the changing margins of accounting in healthcare", *Accounting, Organizations and Society*, Vol. 53, pp. 17-33, doi: 10.1016/j.aos.2016.08.002.

Raghuram, P., Madge, C. and Noxolo, P. (2009), "Rethinking responsibility and care for a postcolonial world", *Geoforum*, Vol. 40 No. 1, pp. 5-13, doi: 10.1016/j.geoforum.2008.07.007.

Ratcliffe, J., Cameron, I., Lancsar, E., Walker, R., Milte, R., Hutchinson, C.L., Swaffer, K. and Parker, S. (2019), "Developing a new quality of life instrument with older people for economic evaluation in aged care: study protocol", *BMJ Open*, Vol. 9 No. 5, e028647, doi: 10.1136/bmjopen-2018-028647.

Reiter, S. (1997), "The ethics of care and new paradigms for accounting practice", *Accounting, Auditing and Accountability Journal*, Vol. 10 No. 3, pp. 299-324, doi: 10.1108/09513579710178098.

Rentfro, R. and Hooks, K.L. (2006), "Ethics of care and decisions of financial statement preparers to manage earnings", in *Research on Professional Responsibility and Ethics in Accounting*, Emerald Group Publishing, pp. 127-148.

Roberts, J. (1991), "The possibilities of accountability", *Accounting, Organizations and Society*, Vol. 16 No. 4, pp. 355-368, doi: 10.1016/0361-3682(91)90027-C.

Roberts, J. (2009), "No one is perfect: the limits of transparency and an ethic for 'intelligent'accountability", *Accounting, Organizations and Society*, Vol. 34 No. 8, pp. 957-970, doi: 10.1016/j.aos.2009.04.005.

Royal Commission into Aged Care Quality and Safety (2021), *Final report: Care, Dignity and Respect*, Commonwealth of Australia, available at: https://www.royalcommission.gov.au/aged-care/final-report

Royal Commissions (n.d.a), "Aged care quality and safety", available at: https://www.royalcommission.gov.au/aged-care

Royal Commissions (n.d.b), "Royal Commission into aged care quality and safety, terms of reference", available at: https://webarchive.nla.gov.au/awa/20190208061113/

Schuchter, P. and Heller, A. (2018), "The care dialog: the 'ethics of care' approach and its importance for clinical ethics consultation", *Medicine, Health Care and Philosophy*, Vol. 21 No. 1, pp. 51-62, doi: 10.1007/s11019-017-9784-z.

Scobie, M., Lee, B. and Smyth, S. (2023), "Grounded accountability and Indigenous self-determination", *Critical Perspectives on Accounting*, Vol. 92, doi: 10.1016/j.cpa.2020.102198.

Shearer, T. (2002), "Ethics and accountability: from the for-itself to the for-the-other", *Accounting, Organizations and Society*, Vol. 27 No. 6, pp. 541-573, doi: 10.1016/S0361-3682(01)00036-8.

Siette, J., Knaggs, G.T., Zurynski, Y., Ratcliffe, J., Dodds, L. and Westbrook, J. (2021), "Systematic review of 29 self-report instruments for assessing quality of life in older adults receiving aged care services", *BMJ Open*, Vol. 11 No. 11, e050892, doi: 10.1136/bmjopen-2021-050892.

Sturmberg, J.P. and Len, G. (2019), "'False accountability': the harmful consequences of bureaucratic rigour for aged care residents", *Australian Journal of General Practice*, Vol. 48 No. 11, pp. 803-808, doi: 10.31128/ajgp-04-19-4907.

Tani, M., Cheng, Z., Piracha, M. and Wang, B.Z. (2022), "Ageing, health, loneliness and wellbeing", *Social Indicators Research*, Vol. 160 No. 2, pp. 791-807, doi: 10.1007/s11205-020-02450-4.

Theurer, K., Ben Mortenson, W., Stone, V.R., Suto, M., Timonen, V. and Rozanova, J. (2015), "The need for a social revolution in residential care", *Journal of Aging Studies*, Vol. 35, pp. 201-210, doi: 10.1016/j.jaging.2015.08.011.

Tregidga, H. and Milne, M.J. (2020), "Not at our table: stakeholder exclusion and ant/agonistic engagements", *Critical Perspectives on Accounting*, Vol. 85, 102265, doi: 10.1016/j.cpa.2020.102265.

Tronto, J.C. (2013), *Caring Democracy : Markets, Equality, and Justice*, New York University Press, New York, NY, doi: 10.18574/9780814770450.

Twyford, E. (2023), "Crisis accountability and aged 'care' during COVID-19", *Meditari Accountancy Research*, Vol. 31 No. 1, pp. 27-51, doi: 10.1108/MEDAR-05-2021-1296.

Twyford, E., Rowe, R. and Andrew, J. (2025), "Financial gaslighting: the financialisation of care in later life", *Critical Perspectives on Accounting*, Vol. 101, 102788, doi: 10.1016/j.cpa.2025.102788.

van Zyl, H. and Claeyé, F. (2018), "Up and down and inside out: where do we stand on NGO accountability?", *European Journal of Development Research*, Vol. 31 No. 3, pp. 604-619, doi: 10.1057/s41287-018-0170-3.

Walker, C.C., Druckman, A. and Jackson, T. (2022), "A critique of the marketisation of long-term residential and nursing home care", *The Lancet. Healthy Longevity*, Vol. 3 No. 4, pp. e298-e306, doi: 10.1016/s2666-7568(22)00040-x.

Wällstedt, N. (2019), "Sources of dissension: the making and breaking of the individual in Swedish aged care", *Accounting, Organizations and Society*, Vol. 80, 101077, doi: 10.1016/j.aos.2019.101077.

Wellens, L. and Jegers, M. (2017), "Beneficiaries' participation in development organizations through local partners: a case study in Southern Africa", *Development Policy Review*, Vol. 35 No. S2, pp. 196-213, doi: 10.1111/dpr.12279.

World Health Organization (2024), "Abuse of older people", available at: https://www.who.int/news-room/fact-sheets/detail/abuse-of-older-people (accessed 22 September 2025).

Yasmin, S. and Ghafran, C. (2021), "Accountability and legitimacy of non-profit organisations: challenging the current status quo and identifying avenues for future research", *Financial Accountability and Management*, Vol. 37 No. 4, pp. 399-418, doi: 10.1111/faam.12280.

Yasmin, S., Ghafran, C. and Haslam, J. (2021), "Centre-staging beneficiaries in charity accountability: insights from an Islamic post-secular perspective", *Critical Perspectives on Accounting*, Vol. 75, 102167, doi: 10.1016/j.cpa.2020.102167.

Yon, Y., Ramiro-Gonzalez, M., Mikton, C., Huber, M. and Sethi, D. (2018), "The prevalence of elder abuse in institutional settings: a systematic review and meta-analysis", *European Journal of Public Health*, Vol. 29 No. 1, pp. 58-67, doi: 10.1093/eurpub/cky093.

Corresponding author
Kylie L. Kingston can be contacted at: k.kingston@qut.edu.au