MOORE

Case Study - Strengthening Care Minute Reporting

Helping a residential aged care provider build a clear, defensible framework for care minute compliance and reporting.

SETTING THE SCENE

Care minutes have quickly become one of the most scrutinised elements of Residential Aged Care.

Under the AN-ACC funding model, providers must deliver a minimum average number of direct care minutes per resident per day, including a defined proportion of Registered Nurse (RN) time, and they must be able to prove it. Starting in the Aged Care Financial Report 2025-2026, all residential aged care providers will be required to prepare and submit an externally audited Care Minutes Performance Statement.

On paper, this sounds straightforward: count the time RNs, ENs and care workers spend on direct care, exclude non-care activities like training and leave, and report the totals through the Quarterly Financial Report (QFR). In practice, however, the reality is far more complex. What exactly "counts" as a care minute? Who decides? How is it captured and checked? And what happens when different people are doing it in different ways?

This case study describes how we worked with a Residential Aged Care provider that was asking exactly those questions – and discovering it didn't have clear answers.

THE PROBLEM

When we first engaged with the provider, there were strong foundations: committed clinical leaders, a functioning Aged Care Subcommittee, and regular Quality and Patient Safety (QPS) reporting that included care-minute data. Everyone understood care minutes were critical for compliance, funding and safe staffing.

Beneath that, however, the framework was fragile.

Care-minute calculations had developed informally over time. Different staff used different spreadsheets and informal rules. Inclusions and exclusions were not consistently defined. Rostering and reporting systems were capable of producing numbers, but they weren't always producing the same numbers.

Our objective was simple, test whether the design, effectiveness and compliance of their controls were strong enough to reliably:

- Calculate care-minute targets and required staffing levels.
- Roster and deliver the required RN and total care minutes, including 24/7 RN coverage.
- Compile, validate and report accurate care-minute information to the Commonwealth and internal governance forums.

Our recalculations of the first two QFR quarters identified both over- and under-statement of care minutes. Tasks were sometimes counted differently from one month to the next; some shifts were treated in ways that did not align with AN-ACC expectations. The executive team could see the risk: incorrect reporting could lead to regulatory challenge, funding consequences and staffing decisions based on unreliable data. They wanted to move from "we think we're right" to "we know we're right – and we can show how".

OUR APPROACH

To understand what was happening end to end, we traced the journey of a care minute from the point of care all the way to the Board.

On the floor, we walked through how shifts were rostered, how staff recorded their time and how that time was translated into "care minutes". We sat with the AN-ACC and QPS reporting staff, tested their tools and listened carefully to how they made judgement calls.

At the governance end, we reviewed the papers going to the Aged Care Subcommittee and other internal forums. Care minute figures appeared in high level dashboards and QPS summaries, however there was limited analysis conducted on the source of the data.

We then joined the dots in the middle. Using roster and payroll data, we independently recalculated care minutes for Q1 and Q2. Where our figures differed from those in the QFR, we drilled down to identify

why. Sometimes the cause was a simple manual error. More often, it was a structural issue: a lack of shared definitions about what could be included, or inconsistent treatment of mixed duties and shared roles.

Throughout this process, the organisation's transparency made a real difference. Managers were honest about where they were uncertain. Staff were open about workarounds they had developed to make the system "work." That openness allowed us not only to identify the weaknesses but also to see where the strengths lay and how we could build on them.from those in the QFR, we drilled down to identify why. Sometimes the cause was a simple manual error. More often, it was a structural issue: a lack of shared definitions about what could be included, or inconsistent treatment of mixed duties and shared roles.

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WHAT CHANGED

The turning point in the audit came when we moved from identifying issues to reshaping the care-minutes framework with the leadership team.

Rather than simply pointing out errors, we helped the organisation design a clear, formal methodology for care-minute calculation. This involved agreeing in writing on:

- What types of activity counted as direct care
- How to treat tasks that straddled care and non-care time.
- How RN, EN and care worker minutes should be captured and categorised.
- Who was responsible for each step from roster, to calculation, to internal review, to external reporting.

By the end of that process, the organisation no longer relied on tacit knowledge. Staff in different roles across departments had a common reference point. This supported consistency of understanding and more accurate calculations.

We then turned to the control environment. Together we mapped the critical control points – where errors were most likely to arise and where they could best be detected. New checks and balances were introduced: reconciliations between rosters.

and reported minutes, independent review of QFR submissions, and exception reports to flag unusual movements or implausible results.

Finally, we worked with the Chief Financial Officer and the Executive Director of Clinical Services to transform care-minute data from something that was "received" into something that was actively used. Variance analysis, trend commentary and clear escalation pathways were recommended to be built into the reporting pack. When care-minute performance now drifts away from expectations, the forum has both the insight and the mandate to act.

The outcome was not just a better set of numbers; it was a stronger line of sight from resident need to staffing decisions to Board assurance.

THE VALUE

By the time the audit concluded, the organisation had achieved three important shifts.

First, it moved from uncertainty to assurance. Management could explain, step by step, how care-minute figures were derived. They understood where past misstatements had occurred and had confidence that they would not be repeated in the same way.

Second, care-minute data began to support better decisions. With more reliable calculations, leaders could see more clearly where RN presence needed strengthening, where care hours were lagging behind resident acuity and where rosters could be adjusted to meet both clinical and regulatory expectations.

Third, the organisation reduced its exposure to regulatory and financial risk.

WHY THIS STORY IS PROBABLY YOUR STORY TOO

What made this case familiar is that nothing about it was unusual.

Most providers are working incredibly hard to get care minutes right. Yet in many services:

- Methodologies have evolved informally over time.
- Definitions are understood differently by different people.
- Spreadsheets and manual workarounds fill the gaps between systems.
- Governance forums receive numbers but don't always interrogate them.

If you recognise aspects of this in your own organisation, it is worth asking:

- Could we explain, to an external reviewer, exactly how our care minutes are calculated?
- Would two different people, working independently, reach the same care-minute figure for the same roster?
- When our care-minute numbers move, do we know why - and do we act?

If any of those answers are "no" or "not confidently," you are not alone. But it is also an indication that the control environment may not be as strong as it needs to be in a sector where care-minute scrutiny is only increasing.

HOW WE CAN HELP

Our work with this provider is one example of how a focused internal audit can turn care-minute uncertainty into a structured, defensible framework. Depending on where you are in your journey, we can:

- Independently review and recalculate your care-minute figures.
- Help you design and document a clear, organisation-wide methodology.
- Map and strengthen controls from rostering through to QFR reporting.
- Reshape governance reporting so care-minute information prompts action, not just awareness.
- Build capability in clinical, finance and quality teams to sustain the framework over time.

The aim is not merely compliance. It is to ensure that care-minute data genuinely informs staffing and supports the quality of care residents receive.

"This review has helped bring clarity and consistency to our care minutes calculations. It has supported us to develop a clear methodology, stronger controls and greater confidence in the numbers we report."

Director

ABOUT WILSON TANG

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Wilson has worked in both professional services and industry/corporate teams providing real opportunities for improvement to clients. Specifically, helping organisations in identifying process gaps and providing value adding recommendations to enhance risk and process maturity.

With his deep operational and audit expertise, Wilson is adept in ensuring there is a balance between the organisation's risk appetite and process operating efficiencies. Experience includes the review of internal audit functions, the management of financial, operational and compliance audits, assessment of audit methodology and risk management framework reviews.

About Moore Australia

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