

**Australian Government
Department of Health**

**Proposal for a new residential aged care
funding model**

Occupational Therapy Australia submission

May 2019

Introduction

Occupational Therapy Australia (OTA) welcomes the opportunity to provide a written submission to the Department of Health on a proposed new residential aged care funding model.

OTA is the professional association and peak representative body for occupational therapists in Australia. As of March 2019, there were more than 21,000 registered occupational therapists working across the government, non-government, private and community sectors in Australia. Occupational therapists are allied health professionals whose role is to enable their clients to participate in meaningful and productive activities.

Occupational therapists provide services such as physical and mental health therapy, vocational rehabilitation, chronic disease management, assessments for assistive technology and home modifications, and key disability supports and services.

Occupational therapists play a key role in providing aged care services to older people, both in the community and in residential aged care facilities (RACFs). Occupational therapists work with older people with age-related conditions such as poor balance and coordination, memory loss and confusion, and vision and hearing loss, which lead to changes in their ability to participate in the meaningful activities of everyday life.

This submission outlines concerns raised by OTA members in regard to the existing Aged Care Funding Instrument (ACFI), and responds to the questions asked in the consultation paper on the proposed new model.

Occupational therapists – a wasted resource

Occupational therapists report that the ACFI, the resource allocation instrument used to assign funding to RACFs, does not take into account the full breadth of services that occupational therapists are trained, qualified and eminently able to provide. The interpretation and application of the ACFI is not holistic enough and does not support therapeutic engagement.

The ACFI is profoundly flawed; it is not aimed at improved or sustained quality of life, and residents are therefore missing out on goal or function-directed therapy. This is professionally frustrating for occupational therapists and a personal tragedy for residents. OTA has also been advised that clients with dementia are disengaged in the current model.

Pain management is not the totality of occupational therapists' skills and experience in chronic disease management. Occupational therapy is not about simply managing pain; rather, occupational therapists are trained to assess changes in a person's functional capacity and promote reablement.

Occupational therapists are trained in assessment and management of pain as part of undergraduate and graduate entry curricula. The occupational therapy management of pain may use modalities common to other disciplines (such as relaxation, massage, time management, cognitive

strategies and environmental adaptation). However, the unique contribution of occupational therapy to pain management is the occupational analysis and occupational adaptation approach – that is, person-centred evaluation of goals, tasks or occupations, and environments, with judicious use of a range of modalities to work towards occupational engagement. Additionally, pain in older people, particularly those with dementia, is complex to assess and treat and requires a multidisciplinary and multifaceted response. Simply using remediation strategies such as massage, TENS, ultrasound and acupuncture, is unlikely to successfully manage pain in an older person.

Any enlightened aged care system would enable and encourage occupational therapists to provide an enhanced range of interventions to patients in RACFs, in line with best practice and evidence-based care.

OTA understands that companies involved in hiring occupational therapists and physiotherapists to perform pain management under ACFI items 4a and 4b tend to hire new graduates. There is a very high staff turnover rate because of the pressure to see high volumes of clients and provide only massages – usually using a hand massager. We are advised there is no real occupational therapy or physiotherapy work involved in this, and there is a great deal of pressure to meet a daily quota – 60 plus people is not unusual, meaning therapists might only see a person for about three minutes.

Other therapists have reported that they have been employed to deliver pain management programs so that RACFs can claim extra funding using the ACFI. Many are finding that their work roles do not allow for ‘occupational practice’ and at times they are being asked to work ‘out of scope’. Several occupational therapists had been trained by the facility in various modalities (such as transcutaneous electrical nerve stimulation (TENS), ultrasound and acupuncture) but were concerned that, among other things, they did not have the scope to make these interventions occupationally relevant to clients.

Quite often residents do not display overt signs of pain. In situations such as these, the skillset of an occupational therapist may be required to assess their care needs. This can reduce the likelihood of chronic pain and reduce hospital readmissions.

Multidisciplinary care teams are needed in all facilities to provide a range of treatment options for residents who may be suffering from a multitude of conditions. There should be ongoing dialogue between members of a client’s care team to better manage their condition and identify the most appropriate interventions.

The attention of the department is drawn to a recent study of the widespread failure of RACFs to value and appropriately deploy the expertise of occupational therapists:

<https://www.otaus.com.au/sitebuilder/practicesupport1/knowledge/asset/files/385/occupationaltherapistsworkinginresidentialagedcarereport.pdf>

Case Study One

I am an occupational therapist who has worked in a number of RACFs. I responded to a job advertisement and was promised I would gain experience across a range of clinical skills and have opportunities to perform splinting. This was completely false, as the job only involved managing the 4a/4b caseload using hand massagers. Residents often do not want a massage, however management strongly encourages staff to ask again and again if it is initially refused. If they continually refuse, the manager of the facility will talk to the resident and coerce them to change their mind.

I have never worked with any residents who refused, as I require consent before touching someone. There are many clients with dementia who are unable to provide meaningful consent due to their condition.

I saw many opportunities to apply my expertise as a clinician, however I was rebuffed by the facility and my employer at every turn. One example of this is a timed toileting program for a resident who was having to wait too long for a nurse to take them to the toilet, which is a significant falls risk. This resident and others were forced to wear continence pads that meant that conditions like thrush were very common. One resident was treated for this weekly, rather than just being taken to the toilet when I suggested.

I believe that other residents were chemically restrained if they were perceived as annoying (eg. moving around the facility confused and asking the nurses what they should be doing). Those with dementia can be seen as merely a distraction to nursing staff. More stimulating, personalised diversional therapy, and occupational therapy-based environmental recommendations, would address this problem.

On another occasion, I attempted to receive mentoring to help a resident whose splint was the wrong size and digging into her arm, only to learn that the company I worked for would only take measurements and send these away to New Zealand where a splint would be made at a cost of around \$400 to the resident.

Case Study Two

I am an occupational therapist that has worked in numerous aged care homes with a few different aged care providers.

The current role of occupational therapists and physiotherapists in residential aged care is to provide pain management which involves massaging people. Residents are placed on a pain management list. Depending on what list a person is on – treatment will be for 20 minutes or 8 minutes. Sometimes, as an alternative to massage, we take residents for a walk or we do a passive range of motion or gentle exercises.

We are also responsible for doing falls assessments, mobility assessments and wheelchair assessments. However, these tasks are not a priority. The pain management lists must be completed. Therapists are expected to work late to complete these types of assessments.

The day is consistently busy because there is a list of about 30 or more clients to see. There is considerable time spent trying to find residents and also trying to fit into what else is happening for them. For example, someone might have visitors, someone might be getting their hair done. In this case we keep checking to see when they will be available for treatment.

Sometimes residents don't feel like having treatment because they might be tired. Many residents have dementia and they do not understand why you are there.

The turnover rate for occupational therapists and physiotherapists in aged care is very high because the work is repetitive, time limited and scripted. There is limited scope to use professional skills. It seems that staff leave the positions after about 3 months or as soon as they can find another job. New graduate occupational therapists have asked me "why do I need a degree for this". They feel that the work is "boring" and "not helping" anyone.

Most of the physiotherapists that I have worked with in aged care are not fully registered with AHPRA. Many are from other countries. This means that the aged care providers do not have to pay them the same rates as registered professionals.

There is a chronic shortage of occupational therapists and physiotherapists in aged care. Recruitment agencies are always trying to recruit for aged care. This in itself indicates that there is low job satisfaction in the role.

I have heard of unregistered practitioners being asked to work 11 days straight for very long hours. I thought that this practice was illegal. However, I am told that the company has to fill a set number of hours.

Every appointment is documented electronically. If a resident refuses treatment we are instructed to still document that they have received treatment. This is because a certain number of hours need to be filled. It comes back to funding. It is also because if a person is taken off the treatment list it is difficult to put them back onto the treatment list. As a therapist this would be unlawful and unethical for me to do.

We are told to spend more time with residents that have better cognitive function. We are told if you don't have time don't worry too much about the ones with dementia. We are told to focus on the residents that have good cognitive functioning because we will get audited at some stage. Auditing will involve asking the residents about our service and "we want the cognitive residents to say good things about us". This feels unethical.

It is very obvious that there are not enough care staff. I have seen residents ask to be taken to the toilet and they can easily wait for more than 30 minutes before staff come to help them. This is because care staff are so busy. In places I have worked, there are usually 4 care staff attending to 30

high need residents. Many of these residents won't be mobile. Many cannot feed themselves. Many cannot toilet themselves. Essentially, many residents need the level of care that a newborn baby would need. Child care ratios for newborns are 1:4. It is obvious that we need more care staff. Occupational therapists and physiotherapists will sometimes identify medical issues that residents have e.g. skin tears, eye complaints before care staff have had an opportunity to become aware of these issues.

I have found a resident that has had a fall in a public area of the nursing home but no staff were present because they were busy attending to other residents. I have also prevented a fall from happening in a public space. Once again, I was the only staff member. There should always be staff in the public areas able to talk with residents and make sure they are safe.

Our role and the type of care we are currently providing in aged care is embarrassing. It seems that we can only provide a set service (pain management) because that is what we are funded to do. This type of care does not give the resident any choice. It is not person centred. The quality of the care is substandard. It is not individualised care.

Occupational therapists are highly skilled and could provide so much more in residential aged care. Here are some examples

- *Provide education groups for residents about health issues or areas of interest;*
- *Facilitate support groups for families;*
- *Provide grief support and counselling;*
- *Modify people's rooms to improve safety and prevent falls;*
- *Modify other areas of the nursing home to improve safety and prevent falls;*
- *Help plan people's leave so that falls are prevented while someone is on leave;*
- *Help facilitate residents to achieve their own goals while they are in aged care. For example, this could be to help them to attend an event, help them to learn a skill etc;*
- *Help facilitate residents to access the community;*
- *Prescribe equipment to prevent falls;*
- *Run exercise classes with specific knowledge of ageing bodies;*
- *Walking groups;*
- *Help build family relationships;*
- *Help residents with age appropriate life skills;*
- *Shower assessments;*
- *Assessment of function;*
- *Assist younger residents with NDIS applications;*
- *Assist younger residents to find suitable community accommodation;*
- *Assist residents with disabilities with NDIS applications;*
- *Assist residents to maintain independence in relevant life skills;*
- *Eating assessments;*
- *Prescription of modifications and devices to assist with independence e.g. built up cutlery;*
- *Mobility assessments;*
- *Falls assessments; and*
- *Occupation based approaches to managing pain.*

In other areas of practice occupational therapists are able to develop individualised treatment plans in collaboration with the client and the client's family. Occupational therapists are able to identify what is meaningful for individuals. We are able to set goals with clients and we are able to enable them and assist them to achieve these goals.

Our potential as a profession is limited in residential aged care because we are not able to provide this kind of service. A new role description with a greater scope of practice would be much more beneficial to the residents as well as the professionals.

Case Study Three

I am an occupational therapist in Queensland and have been a member of OTA for a very long time. I worked in residential aged care for approximately four years until recently when I became so disturbed by the situation I left and went off to do something else.

Someone needs to do something about the way occupational therapists are treated in the sector. I was so disrespected and bullied while working in residential aged care.

The facilities are always completely run by nurses and they made it very clear that any professional opinion I may have was not welcome. This happened to me in three different facilities.

Physios are doing all the functional assessments and untrained care staff are organising equipment.

Occupational therapists are being made to do massage after massage all day long, in all sorts of awkward and unsafe positions. Massage is not really in our scope and if a remedial massage therapist was hired to do that job, they wouldn't do it without a correctly set up massage table.

It's not just the residents who are being abused in residential aged care.

I worked for many years in aged care in the community, where occupational therapists are a valued member of a team and are involved and valued in the care of the elderly.

What happens when the elderly are admitted to residential aged care? Nurses and physios take over, other professionals are shut out and no one is working within their scope of practice.

As we know, occupational therapists are able to assist the elderly to maintain their independence, mobility and quality of life to their maximum ability.

We are also able to assist in rehabilitation following falls and fractures, so commonly a cause of admission to residential aged care.

I can share an experience which highlights the unbalance and abuse of power that goes on in nursing, but I guess they are under pressure from the profit driven companies who own these facilities.

I assisted an elderly woman to mobilise following a femoral fracture which was the reason she was admitted to residential aged care. Following admission, she was bed-ridden and several months later was cleared to commence full weight bearing.

Her sitting and standing balance were good, so I assisted her to mobilise off the bed and she progressed to walking around her ward using a four wheeled walker.

At 90 years of age and in a residential aged care facility, this was quite an achievement. Especially since I was the only staff member willing to take an interest and spend the time with her.

It took a great deal of courage and determination on her part.

Her goal was to be able to walk to the toilet with one assistant and this was definitely achievable.

Well, the facility manager got wind of it and suddenly overnight, this resident became very weak, unable to weight bear, at high risk of a fall and was put back to full bed care.

She had been medicated, and never got off that bed again.

I have seen example after example of nursing approaches deteriorating residents' mobility and independence.

I can only think that it is for funding, since the lower resident mobility is the more money can be claimed through ACFI.

So, there is a financial incentive to remove resident mobility/independence.

Some nurses seem to be more than willing to medicate residents to keep them quiet and in bed.

Resident medical conditions need to be looked at more closely prior to admission, and funding decided according to the predicted course of their medical condition.

The nursing profession needs to be held to account, and if allied health can have a strong involvement, and its opinions respected at admission and during residency, then perhaps this corruption and gouging of funds can be slowed or halted.

I was looking again at the ACFI review and note that government is continuing to only fund physiotherapy in the form of timed physical therapy sessions. There is no funding for occupational therapy, speech pathology, psychology.

There is still no recognition of occupational therapy and what it can offer in the way of accurate Activities of Daily Living (ADL)/Functional Assessments and also Cognitive Assessment and Mental Health.

Occupational therapists have so much to offer yet are shut out due to the funding model.

Nurses are being required to carry out all the ADL assessment as well as cognitive and behavioural assessments.

Also, why aren't allied health professionals in management positions in RACFs?

Psychologists and speech therapists should also have input in residential aged care.

Many nurses don't understand mobility and physios don't understand functional mobility and neither of them understand mental health.

Occupational therapy needs to be included in the funding model in order to have a chance of input into care of the elderly in residential aged care.

Recommendation 1: Aged care facilities should be required to clearly specify the duties and responsibilities involved in any positions they advertise. Additionally, any false claims regarding opportunities to gain experience in a particular area should be thoroughly investigated by the relevant authority.

Recommendation 2: Interventions and modalities funded under the ACFI should be expanded to take into account the broad scope of occupational therapy practice. Currently, residents requiring pain management are limited to a choice of transcutaneous electrical nerve stimulation (TENS) or massage, however there are other occupational therapy interventions that may be more beneficial (eg. reviewing seating/posture, or prescribing aids and equipment to increase mobility).

Recommendation 3: Aged care facilities should be required to invest in consumer-focused aged care teams that include allied health professionals such as occupational therapists. This would enable information sharing and provide for greater awareness of the roles of the different health professionals, helping ensure more holistic and coordinated supports and services.

Responses to questions on the proposed new funding model

1. Are there any risks or benefits of the proposed funding model that have not been identified?

In regard to the fixed component of the new funding model – will this be fixed across all beds funded by the government irrespective of the type of accommodation or area? We realise there is a change in the fixed cost for remote and very remote facilities etc., however additional clarity is needed around the differences in rural and urban areas. How will this impact innovation and motivation to develop different environments/buildings for residential care? Will the funding be sufficient to

encourage organisations to be innovative with the construction of different models of aged care accommodation? (for example, costs related to having four beds per room as opposed to a single room and bathroom or constructing 'village' type accommodation that offers more opportunity to maintain independence, health and wellbeing). Will these types of accommodation only be offered to people who can afford them/make significant contributions?

Will the non-payment of the 'adjustment payment' for residents who transfer between homes disadvantage people who need to move due to a variety of reasons (e.g. family members moving interstate and wishing to have loved ones near them)?

2. Are the proposed resident assessment and classification processes appropriate? If not, why not?

The resident assessments are robust and provide a sound basis for funding decisions and they would represent a significant improvement on the current model. However, as the sector develops it may be worth considering moving from an impairment model (which the proposed changes continue to be) to an outcome based, wellbeing and participation focused assessment system that highlights factors such as person-centredness. We should also give consideration to often overlooked aspects of the person such as spirituality and sexuality (Sjogren et al, 2017).

It would be advantageous to have some process that allows health professionals and others to communicate information about resident cognitive and functional status to the independent assessors. This would support reassessment and provide more robust information related to a variety of factors that can impact on behaviours that may not be observed in a one-hour assessment.

For example, one occupational therapist reported engaging with a gentleman who was very placid, easy-going and appropriately responsive who interacted with similar residents in a quiet environment. However, he became very aggressive when faced with another resident who has dementia and exhibits loud vocal sounds. These types of behaviours are often not observed when undertaking a short one-hour assessment.

5. Should the Commonwealth consider the introduction of reassessment charges for services that trigger unnecessary reassessments?

What would constitute an unnecessary assessment? For example, would this be a penalty charge post assessment if no change was observed?

10. Which transition option do you prefer? Why?

AND

11. Are there any other approaches that should be considered?

OTA's view on this relates to organisations that have employed many staff who are required to implement interventions specifically funded by the ACFI and to meet standards currently set. During any transition, there needs to be a period of time to support the changing environment and ensure

staff can be re-deployed, and RACFs continue to be viable options and able to offer quality care for residents.

Perhaps the resources for care planning (refer to questions in section 11) will absorb the staff resources into other activities that address residents' needs in more holistic way, such as low-threshold (i.e. low input cost) physical activities, found by Cichocki et al (2015) in an Australian based randomised controlled trial of occupational and physiotherapy interventions in residential aged care to result in significant subjective improvements in health status, quality of life and to have a positive effect on overall function.

12. What are the implications of ceasing ACFI assessments in relation to care planning activities?

Would this mean that the funding component for care would be an amount that could be spent in any way the facility and the coordinators of care felt would meet the resident's needs? Currently, the ACFI is tied to a particular intervention (e.g. pain management where residents are provided regulated interventions for a set period of time, despite there being no robust evidence in support of this approach, particularly for those with dementia (Savvas and Gibson, 2015)). Therefore, are there risks that care services could be compromised? What safeguards would be put in place to ensure the funding is spent on care and approaches (reducing resident pain, increasing resident wellbeing) that are in line with the evidence base and with contemporary and international best practice, such as that of person-centred care which promotes a continuity of the self and their usual and meaningful daily activities and routines (Edvardsson et al, 2010)?

13. Do you support the development of a best practice needs identification and care planning assessment tool for use by residential facilities?

Yes, OTA believes this is a minimum need. This will be important for ensuring residents have access to evidence-based health and social care and guidance (for aged care facilities) in developing care plans that support wellbeing.

14. Do you support a requirement for care planning assessments to be undertaken at least once a year for all residents, with outcomes discussed with residents and carers?

Yes, however care plans need to be dynamic and must be reviewed regularly to support any changing needs that are identified by the resident, their carers/family and facility staff. Seamless review processes that identify what's working and what's not with flexible work practices aiming for best outcomes would be ideal. The word 'seamless' is used to set up review processes that are non-invasive and make people feel like they are continually being assessed. Residents should be viewed as home owners and enjoy the same freedoms and rights that community home owners have, while also having good access to the medical and social supports they need.

Conclusion

OTA thanks the department for the opportunity to provide feedback on the new funding model. We would be happy to provide further information on any of the issues raised in our submission should this be required.

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