Royal Commission into Aged Care Quality and Safety

Interim Report

Occupational Therapy Australia submission

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Introduction

Occupational Therapy Australia (OTA) welcomes the opportunity to make a submission in response to the interim report delivered by the Royal Commission into Aged Care Quality and Safety on 31 October 2019.

OTA is the professional association and peak representative body for occupational therapists in Australia. More than 23,000 registered occupational therapists currently work across the government, non-government, private and community sectors in Australia (AHPRA, 2020). Occupational therapists are allied health professionals whose role is to enable their clients to participate in meaningful and productive activities.

Occupational therapists provide holistic healthcare to people of all ages, including older Australians accessing aged care services (OTA, 2020).

OTA welcomed the release of the Royal Commission's interim report and the preliminary findings contained therein. The Commissioners have performed a valuable service in drawing the nation's attention to the overwhelming failure of the aged care system to meet the needs of the elderly.

OTA offers the following observations in response to the interim findings and recommendations.

Workforce Matters – Attraction and Retention

OTA is pleased that the Royal Commission shares its commitment to enhancing the presence of skilled nurses, doctors and allied health professionals in Residential Aged Care Facilities (RACFs). As OTA has previously noted, RACFs generally employ too few staff, and fewer still with the necessary skills, qualifications and experience to provide adequate healthcare to their residents.

According to the *Interim Report* (2019), RACFs can experience "difficulties attracting allied health practitioners such as physiotherapists and occupational therapists" to work in their facilities (p. 211). This is true both of regional areas and more generally. OTA understands that the Royal Commission will continue to examine this issue in the months ahead.

Accordingly, OTA reiterates the key disincentives for occupational therapists to remain in RACF roles.

Undervaluing occupational therapy in RACFs

Occupational therapists are trained to holistically assess the needs of a client and conduct a range of interventions. These include, but are not limited to:

- Prevention, assessment and management of chronic disease and illness (Garvey et al., 2018);
- Prescription of equipment, home modifications and adaptive strategies to restore function, prevent pressure injuries and promote independence (Rahja, 2018); and
- Provision of a range of interventions to support positive ageing and wellbeing across the lifespan (Frank et al., 2017; Nielson et al., 2018).

According to a recent study, older clients of occupational therapists typically present with dementia-related diseases, stroke, arthritis and/or Parkinson's disease; and face complex challenges associated with mobility, falls, frailty, depression and/or anxiety (Hubbard, 2019). It follows that these clients would benefit from the full spectrum of occupational therapy services.

Yet the occupational therapy provided in RACFs consists almost exclusively of pain management (Hubbard 2019).

Furthermore, occupational therapists widely report being contracted to manage said pain using pre-determined treatments. Even when other interventions would be more beneficial, they are restricted to providing transcutaneous electrical nerve stimulation (TENS), massage or heat packs.

This care is not clinically determined. Rather, it is prescribed by RACFs as a means of generating funds under the Aged Care Funding Instrument (ACFI).

We refer the Commissioners to our recent submission to the Department of Health on a proposed new residential aged care funding model:

> *"The ACFI is profoundly flawed; it is not aimed at improved or sustained quality of life…this is professionally frustrating for occupational therapists and a personal tragedy for residents"* (OTA, 2019, p. 2).

Occupational therapists believe that everyone, regardless of age, has the potential to engage in activities they find meaningful (Shanas et al., 2017). The therapy provided to aged care residents should aim to maximise function, health, wellbeing, quality of life and, where possible, independence (Richards et al., 2015). Occupational therapists who are not empowered to perform this role quickly become disillusioned with working in RACFs.

This is supported by a key finding outlined in the *Interim Report* (2019):

> *"If the aged care sector is to attract and retain high quality employees effectively, it must … address the very low enablement level of its workers. 'Enablement' refers to workers' sense of empowerment to be able to do their jobs well"* (p. 227).

Misleading new applicants

On a related matter, OTA is concerned that some RACFs attract occupational therapists through job descriptions which, deliberately or otherwise, are highly misleading.

One OTA member reported responding to a job advertisement which promised the successful applicant would gain experience in a range of clinical skills including splinting. In fact, the role only involved managing the ACFI pain management caseload using hand massagers.

Furthermore, the occupational therapists hired by RACFs to perform pain management roles are typically recent graduates. Once employed, they are often disappointed to find that their role involves no real occupational therapy. Instead, they are placed under a great deal of pressure to see high volumes of clients and provide only massages, heat packs and TENS.

Unfortunately, new graduates often lack the confidence to speak up about these concerns. They may be unsure of exactly what their role should involve and, due to insufficient supervisory structures, have limited access to role modelling for alternative approaches.

OTA understands that those hired as occupational therapists have at times also been asked to work outside the scope of their profession. Several OTA members report being trained by the facility in treatment modalities, such as ultrasound and acupuncture, which are not occupationally relevant to their clients nor taught in any certified occupational therapy course in Australia.

Under these circumstances, it is unsurprising that RACFs experience high rates of staff turnover. To successfully retain their presence in RACFs, occupational therapists must be funded and employed to perform the full scope of occupational therapy practice.

Recommendation 1: Interventions and modalities funded under the ACFI should be expanded to reflect the broad range of occupational therapy practice. Empowering occupational therapists to perform their job well will improve both health outcomes for residents and staff retention rates in RACFs.

Restrictive Practices in RACFs

As OTA noted in its previous submission, understanding and responding to the resident's unmet needs is essential to minimising the behavioural and psychological symptoms of dementia (BPSD), and distress more generally, without restraints.

OTA wholly endorses mandatory training of staff in the care of residents with dementia. OTA also welcomes the call for the Federal Government to address the present overuse of chemical restraints as a matter of urgency, including through the seventh Community Pharmacy Agreement.

However, reliance on restraints in RACFs cannot be addressed through training and regulation alone.

In anticipation of the Commissioners' final recommendations, OTA wishes to reiterate the effectiveness of multidisciplinary health teams in providing non-pharmacological interventions.

Lack of multidisciplinary input

Currently, resident behaviour and medication are often managed by doctors and nurses in professional silos. When allied health practitioners are utilised in RACFs, they typically occupy very narrow roles which do not allow for clinical advice or decision-making.

Aged care residents are also ineligible to access mental health professionals under the Medicare Benefits Schedule (MBS), despite a very obvious need. In 2012, more than half of all permanent residents had symptoms of depression (AIHW, 2013). Anxiety disorders, also, are prevalent, under-reported and treated predominantly with psychotropics in this population (Creighton et al., 2017).

Lack of multidisciplinary input also means that review of existing medication is rare. In some instances, residents continue to take medication which is unnecessary, ineffective or even contributing to an increased risk of falls and cognitive impairment. Though geriatricians and specialised pharmacists are more likely to deprescribe medication, their presence in RACFs is limited.

The role of occupational therapy

OTA takes this opportunity to remind the Commissioners once again of the core purpose of occupational therapy: facilitating participation in the activities of everyday life.

Occupational therapists assess the needs of their clients, engaging in person-centred evaluation of their goals, tasks and environments, then providing treatments or advising adjustments with a view to maximising function and quality of life.

This holistic approach to health, wellbeing and quality of life clearly resonates with what the Royal Commission has heard is required to 'fix' aged care in Australia. Numerous government reports have also drawn this conclusion.

A Matter of Care, the report produced by the Aged Care Workforce Taskforce (2018), asserted that allied health "will play an increasingly bigger and critical role in delivering holistic care services that support positive ageing and reablement and improve the quality of life of consumers" (p. 34). We also note that a key recommendation of *The Oakden Report* was a much greater role for allied health professionals, including occupational therapists, in the successive facility (Groves et al., 2017).

OTA also notes that the *Australian Ageing Agenda* (2020) has described occupational therapy as the "unsung hero" of the aged care sector (p. 52). According to exercise physiologist, Dr Tim Henwood, occupational therapists provide the "essential link" between health, engagement, therapy, home safety and memory support (*Australian Ageing Agenda*, 2020, p. 52).

OTA advocates for not only a greater occupational therapy presence in RACFs, but also greater scope for occupational therapists to harness the breadth of their skills. These include:

- Development and implementation of a personalised Positive Behaviour Support Plan (PBSP);
- Design of the social and physical environment, including layout and use of space, to support positive ageing and improve BPSD (Day et al., 2000; Nielson et al., 2018);
- Prescription of aids, equipment or adaptive strategies, such as energy conservation techniques and alternate seating postures, to improve mobility, independence and function (Rahja 2018); and
- A range of mental health therapies, which occupational therapists are accredited to provide under the Commonwealth Government's *Better Access to Mental Health* Initiative.

Residential In-Reach (RIR) programs

OTA understands that a range of Residential In-Reach (RIR) programs were discussed at the Royal Commission Hearing held in Canberra in December 2019.

RIR programs are generally facilitated by hospitals and primary health networks to provide multidisciplinary health services in nearby RACFs. These teams can comprise occupational therapists,

social workers, physiotherapists, nurses, GPs and geriatricians. They provide subacute healthcare and education in RACFs, aiming to reduce the number of unnecessary hospitalisations.

OTA believes that RIR is a viable option for improving access to multidisciplinary healthcare in RACFs. For example, an occupational therapist could be asked to attend a facility to:

- Respond to dementia-specific confusion and behavioural disturbances;
- Conduct a functional assessment of a resident following a fall; or
- Prescribe aids and equipment which improve a resident's capacity to engage in activities of daily life (ADLs) (Peninsula Health, 2020).

With access to these kinds of allied health and medical services, RACFs would be less reliant on chemical and physical restraints, and residents' quality of life would drastically improve.

OTA acknowledges that there is no one-size-fits-all program. Rather, RIR should be tailored to the needs and resources of the population it services. OTA recommends that any new RIR initiative builds on existing programs and networks in the area.

Recommendation 3: Residents of aged care facilities should have access to mental health services equivalent to those living in the community, including the Better Access items on the MBS.

Recommendation 4: Healthcare in RACFs should be delivered by multidisciplinary teams, which include occupational therapists, to ensure that residents can access a range of treatment options. This could be achieved through expansion of existing Residential In-Reach programs.

Home Care – The Way of the Future

As acknowledged in the *Interim Report* (2019), ageing at home is the growing preference for millions of older Australians. Therefore, it is imperative that people's homes are fit for purpose.

Occupational therapists have the necessary training and skills to ensure that an older person's home is as safe and enabling as possible. This expertise should be integral to home care policy in twenty-first century Australia (Nielson et al., 2019).

Occupational therapy home assessments

Australians who choose to age in place should have access to an occupational therapy functional home and environment assessment. This will ensure they have the best prospect of maintaining independence, with the least possible reliance on paid and unpaid services.

Occupational therapists can also address a client's ongoing need for social contact, even as their mobility declines. This can involve facilitating engagement with local socialising opportunities. For example, OTA members report that Men's Sheds are proving a popular meeting place for older clients in rural towns. Notably, participation in Men's Sheds has been linked with decreased self-reported symptoms of depression among retired men (Culph et al., 2015).

Despite this, there is currently no requirement to offer a client access to an allied health professional under their Home Care Package (HCP) funding. Whilst occupational therapy services are available under the Commonwealth Home Support Programme (CHSP), OTA members advise that it is insufficiently funded to deliver the right services to the right cohort and at the right time.

In any case, failure to engage an occupational therapist in the planning of home care arrangements jeopardises client safety, independence and quality of life. Occupational therapy services should be sufficiently funded to support better outcomes for home care clients.

Assistive equipment and home modifications

OTA notes that assistive equipment received limited attention in the interim report, except in the context of rural communities where it is often particularly difficult to access. Inconsistency of access is certainly a major concern. As noted in our previous submission to the Royal Commission:

> *"It is a postcode-based inequity that severely compromises some Australians' quality of life"* (OTA, 2019, p. 28).

OTA members also advise that funding for assistive equipment is severely limited across all schemes. Some equipment is too costly to provide through HCPs, particularly for clients with high care needs who cannot forgo other services to offset equipment costs.

This is highly regrettable, as the right equipment can enable people to remain at home longer and with greater independence (Scott et al., 2018).

OTA also understands that some home modification services close their books once available funds have been expended, placing older Australians at significant risk for months at a time. This should not be allowed to continue.

Instead, the Commonwealth should develop guidelines for *necessary and reasonable* modifications and equipment; and these should be afforded to clients on the basis of clinically determined need. Adequate controls would ensure that this did not become the pretext for lavish renovations.

Once again, OTA emphasises that assessments should only be undertaken by skilled professionals. This is because inappropriate prescription of equipment and modifications can present clinical risks to the client, including falls and pressure injuries (Gray-Miceli et al., 2018). We note that such assessments are well within the occupational therapy scope of practice (OTA, 2017).

Reablement and restorative care

The *Interim Report* (2019) mentions reablement only once; and only in reference to a previous recommendation from the Productivity Commission (p. 71). Restorative care is primarily cited as an alternative to entering residential care or receiving an HCP (Royal Commission, 2019, p. 49-50).

Therefore, OTA wishes to reiterate the untapped potential of this approach to health and wellbeing.

Reablement and restorative programs – such as regular occupational therapy – can significantly improve an older person's quality of life and lessen their ongoing reliance on costly support services (Langeland et al., 2019). This should be standard practice in aged care. Yet there is currently very little consistency regarding who is and is not prescribed such interventions. Unfortunately, those who do not actively seek these services tend not to receive them.

We direct the Commissioners' attention to a recent proposal from the National Aged Care Alliance (NACA). Namely, NACA endorses provision of a reablement program to all suitable HCP candidates, *prior* to being assigned an ongoing package. Where the client is willing and able, the program would last up to 12 weeks and aim to maximise their independence, function and quality of life (NACA, 2019, p. 11). This could ultimately lower the level of package they require for ongoing care.

Currently, home care clients can access a short term restorative care (STRC) package through an Aged Care Assessment Team (ACAT). OTA members report that demand for these packages far outstrips supply, meaning clients must meet restrictive eligibility criteria to qualify for the service.

Given the personal and financial cost of decreased function, it is imperative that STRC packages be more widely accessible.

ACATs and RAS

OTA acknowledges that the Federal Government briefly considered putting the management of ACATs – which currently include highly skilled occupational therapists – out to tender.

Our members were gravely concerned by this proposal and questioned why the Federal Government would undertake such drastic reform before receiving the Commissioners' final report. It is OTA's view, and the view of our members, that this would lead to greater fragmentation of a service which is in fact highly effective, albeit somewhat under-resourced.

OTA welcomed the announcement by the Hon. Greg Hunt MP that his government was "unlikely to proceed" with the proposed tender (cited in O'Keefe, 2020). It is our sincere hope that the Federal Government will not revive this ill-conceived scheme.

OTA would, however, support the merging of ACAT and RAS to integrate the assessment process and decrease duplication. This would assist the consumer in navigating what is currently a confusing system (Ivanoff et al., 2018).

OTA notes that ACAT and RAS have already merged in some Local Health Districts in New South Wales. Both clients and their carers are benefitting from enhanced cost-effectiveness and clinical governance and reduced duplication and confusion. The lessons learned from this implementation could be replicated across Australia.

Recommendation 5: Funding for occupational therapy services – including home assessment, home modifications and equipment prescription – should be increased across all home care programs.

Recommendation 6: The Commonwealth should develop guidelines for reasonable and necessary home modifications and assistive equipment. These should be afforded to home care clients on the basis of clinical need, as determined by an occupational therapist or other skilled professional.

Recommendation 7: Reablement should be a greater focus of home care. Specifically,

- ***a) The number of STRC packages should be increased and eligibility criteria expanded; and***
- ***b) A reablement program of up to 12 weeks should be available to any HCP candidate who is able and willing to benefit from this approach, prior to receiving their ongoing package.***

Falls Prevention

OTA takes this opportunity to remind the Commissioners that relatively inexpensive measures to prevent falls among the elderly could significantly relieve the pressure on Australia's overstretched health and aged care systems. In fact, falls prevention should rank alongside road safety and obesity in the national consciousness.

Falls are a common – and expensive – occurrence among older Australians. Between 2009 and 2010, one in every 10 days spent in hospital by a person aged 65 years or older was directly attributable to an injurious fall (AIHW, 2013). Furthermore, the average total length of stay per injurious fall incident was estimated to be 15.5 days (AIHW, 2013). According to one study, these hospitalisations typically incur costs of between $6,000 and $18,600 per incident (Watson et al., 2010).

An injurious fall can also be life threatening. Neck of femur (NOF) fractures – the most common kind of hip fracture – are associated with particularly high rates of premature death (AIHW, 2018). According to an Australian study, the mortality rate for patients admitted to hospital with a NOF fracture is 8.1% after 30 days and 21.6% within one year (Chia et al., 2013).

Even in less severe cases, a fall can impair an older person's long-term mobility and independence, often irreversibly. In such instances, they will require higher levels of assistance to continue living at home and may be forced to enter residential care prematurely.

This situation is not only detrimental to the individual's quality of life, but also imposes a financial burden on a system that is already failing to meet a growing demand. Yet falls are easily prevented.

A meta-analysis found that environmental interventions such as simple home modifications can significantly reduce fall risk, especially within high-risk groups (Clemson et al., 2008). Specifically, researchers observed a 39% reduction in falls among high risk participants and a 21% reduction overall (Clemson et al., 2008).

Evidence suggests such measures are also cost-effective, especially when targeted to specific high-risk groups (Frick et al., 2010; Wilson et al., 2017). Indeed, every dollar which individuals, private health funds or governments invest in falls prevention will save the health system multiple dollars. As OTA outlined in its 2018-19 Pre-Budget submission to the Treasury,

> *"But for the presence of an inexpensive grab rail or rubber shower mat, an elderly person would not be occupying an expensive public hospital bed, recovering from a fractured hip and running the risk of contracting pneumonia or a superbug infection"* (OTA, 2017, p. 8).

Recommendation 9: As part of a nationwide falls prevention strategy, the Commonwealth Government should develop guidelines to ensure that all future dwellings include basic falls prevention features or have scope for their addition.

Conclusion

Over the past 18 months, the Royal Commission has heard of the extensive problems facing Australia's aged care system. The existing system is unkind and uncaring towards older people. It entrenches outdated practices which depersonalise the individual and it financially penalises attempts at client-centred care.

It is intrinsically flawed.

It is OTA's belief that occupational therapists, who are trained to holistically address their clients' health, wellbeing and quality of life, can be part of the solution.

In residential aged care, occupational therapists must be funded and empowered to utilise the breadth of their expertise. Greater emphasis must also be placed on reablement and falls prevention, so that the many Australians who choose to age at home can retain high levels of independence, mobility and quality of life.

OTA thanks the Commissioners for the opportunity to comment on their interim findings. Please note that representatives of OTA would gladly appear before the Royal Commission to expand on any of the matters raised in this submission, were the Commissioners to deem this beneficial.

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