# ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY

## OCCUPATIONAL THERAPY AUSTRALIA (OTA) SUBMISSION

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## Introduction

Occupational Therapy Australia (OTA) welcomes the opportunity to provide this submission to the Royal Commission into Aged Care Quality and Safety.

OTA is the professional association and peak representative body for occupational therapists in Australia. As of June 2019, there were around 22,000 nationally 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 provide healthcare to people across all ages, including older Australians accessing aged care services.

## The role of occupational therapists in aged care

Occupational therapists play a vital role in providing aged care services to older people, both in Residential Aged Care Facilities (RACFs) and in the community. These include:

- A range of reablement-focused interventions that aim to enhance health and wellbeing and to preserve, restore, enable and/or improve function and independence (Langeland et al, 2019);
- Assessing and modifying consumers' homes and community environments to enable them to age in place, living at their own homes for longer and participating in their everyday activities (Nielson et al, 2019);
- Prescribing aids, equipment and home modifications to increase safety and minimise the incidence of falls, and to enhance mobility and participation in everyday activities (Pighills et al, 2019);
- Prescribing a range of adaptive strategies and providing education and advice aimed at maintaining or improving people's mobility, independence and function (addressing, for example, joint protection, energy conservation techniques, and falls prevention) (Rahja, 2018);
- The prevention, assessment and management of chronic disease (Garvey et al, 2015); and
- Health and wellbeing services specific to change across the lifespan, including the impact of the environment and its impact on people's independence, and psychological, cognitive, physical and functional health (Behm et al, 2015).

OTA is committed to supporting those occupational therapists working in aged care, particularly as the demand for aged care services rises in line with Australia's ageing population (Grove & Dunkley, 2017; Australian Government Department of Health, 2018).

OTA recently consulted with members who are currently working, or have recently worked, in RACFs. A number of therapists have become disillusioned with these facilities due to the extremely

varied standard of care provided to clients (Connolly et al, 2015). This is simply unacceptable in a country as wealthy as Australia. These failings need to be addressed as a matter of urgency in order to provide older Australians who have no alternative but to enter a RACF with the care they need and deserve.

A recent survey undertaken by a group of occupational therapists (Hubbard, 2019) indicated that although there is ample opportunity to provide "best practice" healthcare to older Australians, occupational therapists are greatly restricted in what they are, and are not, able to prescribe and do.

The survey found that most older Australians being seen by occupational therapists are diagnosed with dementia-related diseases, stroke, arthritis and/or Parkinson's disease, and/or are facing challenges associated with mobility, falls and frailty, depression and/or anxiety.

The occupational therapy provided to residents in RACFs should ideally improve independence, and it should certainly aim to maximise function, quality of life, health and well-being (Richards et al, 2015). However, the survey found that occupational therapy provided to residents of aged care facilities was too often focussed almost exclusively on pain management, and that occupational therapists were being actively trained to provide pre-determined care, and that this care was a means of generating funds via the Aged Care Funding Instrument. OTA notes that this practice was one of the reasons for the recent review of the funding instrument.

Although ageing is often a process of gradual decline, occupational therapists believe that older people, regardless of the severity of their condition, have the potential to engage in activities that are personally meaningful to them (Shanas et al., 2017).

As modelled by the World Health Organisation, health is not just about disease, disability or injury. It is also about activity, participation, personal factors and environmental factors (Liu, 2017). This aligns neatly with the work of occupational therapists, who adopt a holistic approach to health, function, quality of life and well-being.

## The importance of evidence

One of the key challenges facing the aged care sector is the collection of standardised and accurate data to track the care provided in facilities. Ideally, this data should measure: levels of active participation; quality of life and user-satisfaction; the incidence of pressure injuries; medication errors; unexplained weight loss; falls; infection rates; admissions to hospitals; and staffing levels and training.

OTA notes that the disclosure of staffing levels is supported by recent submissions to the Federal Parliament's Inquiry into the *Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018*.

OTA contends that increased transparency is essential to evidence-based consideration of RACFs and the quality of the care they provide for consumers and their carers. Any accreditation and compliance framework, and the requirements it imposes on care providers, will need to be evidence

driven. This will require adequate resourcing to ensure data is collected in a timely and transparent manner.

OTA calls for an aged care system that functions effectively and efficiently, as evidenced by positive outcome measures, such as quality of life indicators and participation in everyday activities (Franck, 2016). Unfortunately, the aged care sector is not currently at a developmental stage which allows for the provision of this evidence. It is the recommendation of OTA that RACFs be subject to the highest and most rigorous standards of accreditation available, such as those that govern health care environments. It is vital that the new Aged Care Quality and Safety Commission's Aged Care Quality Standards, introduced on 1 July 2019, operate to these standards.

## Concerns around the Aged Care Funding Instrument (ACFI)

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 or apply transcutaneous electrical nerve stimulators (TENS). There is no real occupational therapy or physiotherapy work involved in this, and there is often a great deal of pressure in the job to meet a daily quota.

We have received several complaints from members who expressed concern about the suitability of the ACFI system and the subsequent utilisation of funds provided under the Complex Health Care domain.

*Clinical and Managerial Workforce – Provision of complex pain management*
There is increasing demand for occupational therapists to provide pain management services. Although broadly within their scope of practice (Occupational Therapy Australia, 2017), occupational therapists working in this field report that they are unable to implement the range of treatment modalities central to their expertise (Hill, 2016). This is attributable to constraints in the ACFI user guidelines and to RACF management demands.

One occupational therapist who has worked in a number of RACFs reported that they responded to a job advertisement and were promised that they 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 did not want a massage, however management strongly encourage staff to ask again and again if this is refused. If they continually refuse, the manager of the facility will talk to the resident and persuade them to change their mind.

Other therapists have reported that they have been employed to deliver pain management programs so that RACFs can claim extra funding under 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' (in terms of treatment modalities) (Occupational Therapy Australia, 2017). Several occupational therapists had been trained by the facility in various modalities (such as 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 (Hill, 2016).

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. Use of remediation strategies such as massage, TENS, ultrasound and acupuncture, has greater likelihood of success if used in conjunction with other modalities as mentioned above. The ultimate aim is to enable the older person to be comfortable and engaged in purposeful activity, and to minimise pain using non-pharmacological methods (Hill, 2016).

Another occupational therapist who provided feedback to OTA noted that the wording of the ACFI guidelines is far too narrow in that it does not take into account the full breadth of services that occupational therapists are trained to provide. The interpretation and application of the ACFI is not holistic enough and does not support therapeutic engagement. OTA has been advised that clients with dementia are disengaged in the current model – Poulos et al. (2017) recommend a reablement approach in dementia.

Pain management is not the totality of the occupational therapist's 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. Concerns have been raised that the ACFI is not aimed at improved or sustained quality of life, and residents are therefore deprived of goal or function-directed therapy.

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 all their care needs. This can reduce the likelihood of chronic pain and reduce hospital readmissions (Schofield et al, 2018).

Multidisciplinary care teams are needed in all facilities to provide a range of options for residents who may be suffering from a multitude of conditions, and to reduce hospital admissions from residential aged care (Connolly et al, 2016). There should be ongoing dialogue between members of a client's care team to better manage their condition and identify the most appropriate interventions.

Above all, wherever possible, the focus of staff should be on maximising client occupation. This is inherently positive and proactive care and, as such, should be more important than pain management alone. Ageing should be, to the greatest extent possible, an activity.

*Clinical care planning*

An important aspect of clinical care is adopting a holistic approach to care planning (Davitt, Madigan, Rantz, & Skemp 2016). Occupational therapists have the clinical expertise to contribute to the maintenance of skills, capacity building, reablement and the improvement of health and well-being. With a focus on 'activity' and 'doing with', occupational therapists have identified many areas of care planning that are contrary to this wellness approach and may contribute to decline in health, increased staff needs, and overall care costs.

***Recommendation: 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: 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), massage or heat packs. Choice of treatment modality should be clinically determined, as other occupational therapy interventions may be more beneficial (eg. reviewing seating/posture, or prescribing aids and equipment to increase mobility).***

***Recommendation: 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.***

## Abuse of older Australians living in residential aged care facilities

OTA welcomes the recent Council of Attorneys-General *National Plan to Respond to the Abuse of Older Australians (Elder Abuse) 2019 – 2023* as an important step towards a national approach to identifying and responding to abuse and neglect of older Australians.

Although there has been growing media coverage of elder abuse, particularly in RACFs, it has not received the same level of attention as other serious issues, such as domestic violence. OTA believes that the abuse of older Australians needs to be elevated as a policy priority at a national level and accordingly welcomes the establishment of this Royal Commission (Pillemer, Burnes, Riffin, & Lachs, 2016).

The current state-based approach to identifying and responding to elder abuse is fragmented and inconsistent, while concerns have been raised that the lack of a coordinated response has prevented elder abuse agencies sharing best practice research and knowledge. Events such as the National Elder Abuse Conference provide a forum for information and knowledge sharing, however they do not allow agencies to engage in ongoing discussions around long-term strategies for preventing and responding to elder abuse.

OTA believes that the problem with a state-based approach is not that specific initiatives developed by each state and territory are ineffective, but rather that there is a lack of consistency in terms of what services and resources residents in each jurisdiction are able to access.

Many of the state-based initiatives that are currently in place should be included as part of a national elder abuse prevention and response strategy. OTA believes that this strategy should consist of the following:

- The establishment of an interagency taskforce to support a whole-of-government, human rights-based approach to elder abuse prevention;
- A national advertising campaign to raise awareness of elder abuse, promote support services and provide information about reporting requirements. This could be similar to campaigns targeting issues such as domestic violence, and should involve television, print and online advertisements;
- A central access point for service providers to find information about legal frameworks, investigative processes and police powers in each state and territory. A flowchart similar to that developed by the ACT Government would be useful to highlight referral pathways, while a set of nationally consistent guidelines should be developed for aged care organisations and RACFs;
- Better resourcing of existing Commonwealth departments and agencies (such as the Department of Health, the Department of Human Services and the Australian Human Rights Commission) to deal with elder abuse; and
- Funding for peer support networks for health and aged care workers in all Australian states and territories.

**Examples of elder abuse/poor treatment of older people in RACFs**

- A veteran who had suffered a dense stroke had a leg amputated due to poor care. Many aged care facilities are short staffed and residents often develop pressure injuries as a result of care practices hampered by time constraints, inappropriate equipment, or inadequate staff expertise and training.
- There have been reports of nursing home residents being excluded from activities because their behaviour is perceived as problematic, which can lead to social isolation and poorer health outcomes.
- Therapists who have worked in RACFs reported that residents are sometimes discouraged from walking or engaging in physical activity and, as a result, remain in bed all day.
- Concerns have been raised about poor hygiene in RACFs – one therapist noted that on numerous occasions they have found mould in cups. Some residents are non-verbal and therefore unable to communicate their concerns, meaning these types of occurrences may go unnoticed for long periods of time.
- Older people in RACFs are often very sedentary and may not stand at all. Exercise programs do not actually engage residents in physical activity – these may instead involve an activity

such as watching a DVD. When families pay for services privately, there is much more scope to tailor programs to residents' needs and interests.

***Recommendation: A coordinated approach to preventing and responding to abuse of older Australians should be developed at a national level and led by an interagency taskforce. This should involve a national advertising campaign to raise awareness of elder abuse, a central access point for information and support, better resourcing of existing agencies, and funding for peer support networks.***

***Recommendation: Primary Health Networks (PHNs) should work to educate the community about abuse of older Australians in the health, disability and aged care sectors, and develop resources to assist staff in RACFs and the community to identify common signs of abuse.***

## Reporting requirements and privacy concerns

OTA understands that although staff in RACFs are obligated to report any falls a resident has to the Clinical Manager, they are not reported to a higher authority such as a government agency.

Privacy concerns are another barrier to responding to abuse and poor practices. Calls for the use of video surveillance in residential aged care facilities increased after footage was aired of a staff member appearing to suffocate a resident at a facility in South Australia. The staff member was later convicted of aggravated assault.

OTA joins other interested parties in calling for the use of video surveillance in private rooms of aged care facilities to be considered. The case of elder abuse in South Australia mentioned above was only uncovered because the patient's daughter placed a hidden camera in his room.

OTA believes that video surveillance should be allowed in private rooms with the permission of residents, or their family members and guardians.

Providing feedback on the progress of complaints in RACFs and the indicative timeframes for their resolution would assist all concerned.

***Recommendation: States and territories should enact mandatory reporting legislation that requires health professionals to report serious cases of abuse of older Australians to authorities.***

***Recommendation: Video surveillance should be allowed in private rooms of residential aged care facilities with the permission of residents or their families and guardians.***

***Recommendation: All aged care facilities should be required to publicly display a notice on how to report complaints.***

## Understaffed facilities

Arguably the most pertinent factor contributing to poor standards of care in RACFs is chronic understaffing (Harrington, Schnelle, McGregor, & Simmons, 2016). This is a common trend across RACFs, despite the fact that these facilities are often allocated a more than adequate level of funding through the ACFI.

There is currently a lack of occupational therapists and other allied health professionals in RACFs. Some facilities do not have an occupational therapist as a member of staff. Other facilities may engage an occupational therapist or physiotherapist; however, this may be for only a few hours a week.

In addition to this, staff in RACFs are often inexperienced and underqualified. OTA understands that many facilities use personal care assistants (PCAs) to assist residents to participate in activities of daily living (ADLs). There is no registration body overseeing PCAs.

OTA was advised by an occupational therapist working in residential aged care that it is not uncommon for residents to have falls and fractures, or be left bedbound due to a lack of care. The therapist reported that they are often required to brush residents' teeth, get them water or reposition them. They naturally feel that they have a duty of care to perform these tasks, despite the fact that they are not strictly within the remit of their clinical role.

Understaffing leads to a lack of proper attention being paid to the needs of residents and a lack of patience being shown by staff. There is currently no national requirement for a registered nurse (RN) to be on-site at RACFs – this could affect a number of residents, particularly those who require palliative care and care in end stage dementia. OTA believes that RNs are needed to carry out treatments on each shift, especially with the increase in palliative care clients within facilities (for example, using syringe drivers to eliminate pain).

OTA believes that there needs to be greater engagement with residents (Tak, Kedia, Tongumpun, & Hong, 2015). This would facilitate mobilisation, helping to eliminate pressure injuries and prevent falls. There should also be more individual diversional therapy for clients who are disruptive or have behaviour problems that affect other residents.

Provision of assistive equipment should be overseen by an occupational therapist, or other suitable allied health professional, as they are best placed to prescribe equipment that meets the needs of each client. There have been situations where clients are given equipment that is not suitable simply because it is available in the storeroom.

***Recommendation: There should be a legislated requirement in all states and territories that at least one registered nurse (RN) must be on-site at all times in residential aged care facilities (RACFs).***

***Recommendation: Diversional therapy programs in RACFs should be tailored to the individual needs and interests of residents, particularly those with behavioural issues that can cause them to be disruptive. This should be the key consideration before restrictive practices are implemented.***

***Recommendation: Provision of assistive equipment in RACFs should be overseen by a suitably trained occupational therapist who can assess the functional needs of residents and prescribe the most appropriate equipment.***

## Quality of staff training

One of the leading causes of abuse and poor clinical practices in RACFs is inadequate staff training. Concerns have been raised that many aged care staff may not have sufficient knowledge of appropriate care techniques, particularly when working with people with dementia, and adequate cultural competency. Australia currently has a growing cohort of ageing people from culturally and linguistically diverse backgrounds, and is actively seeking RACF workers from these backgrounds to support residents. There may be additional considerations and challenges involved in offering adequate training to staff members for whom English is a second language.

Recent anecdotal evidence suggests that due to staff shortages in aged care, current supervision and mentoring structures for new graduate occupational therapists are inadequate. Staff are more likely to be promoted into supervisory roles because of their clinical experience rather than leadership skills, which can affect the quality of supervision that graduates receive (Hodgkin, Warburton, Savy, & Moore, 2017).

Additionally, many privately funded or community based aged care facilities do not have the funding to offer sufficient clinical governance, practice leadership and supervision structures that are necessary to develop new graduates.

Inadequate training and supervisory structures, as well as a lack of professional development opportunities for staff, can lead to neglect of elderly residents in aged care facilities. For example, there are many cases of residents not eating/drinking properly and developing pressure injuries as a result of a lack of movement (Price, Kennedy, Rando, Dyer, & Boylan, 2017).

OTA believes that aged care facilities should be required to have in place professional/clinical leadership structures that coordinate and monitor the implementation of good practice and clinical guidelines. These should address matters such as clinical supervision, accountability and the reduction of risk factors contributing to abuse/neglect and other harmful practices.

One occupational therapist noted that there are not enough staff to support residents, and training (for instance manual handling reviewing and upskilling in skin degradation) is not regularly maintained with nursing assistant staff. A lack of training in manual handling results in residents using the wrong equipment, which can further impair their physical condition. This needs to be updated annually and whenever a major piece of equipment is purchased.

***Recommendation: New graduate occupational therapists working in aged care (in private, government and community practice) should meet regularly with a supervisor who can monitor and support their progress.***

***Recommendation: Staff in all aged care organisations should be funded to complete refresher training annually through online learning modules and/or practical sessions, to ensure that their skills and experience remain up to date.***

***Recommendation: Direct care service providers should receive mandatory training in trauma informed care to enhance their ability to identify and respond to signs of abuse. The training should be sensitive to the many different ways people live their lives and ensure privacy and respect for this diversity is maintained.***

***Recommendation: All staff working in aged care should undergo training in the care of dementia clients, behaviour management and harm minimisation.***

## Accreditation Standards for residential aged care

It is unclear what levels of knowledge staff in RACFs have of the quality standards for aged care. A key question to consider from an occupational therapy perspective is how therapists can meet these standards when many are contracted into facilities on an as-needs basis.

OTA believes that the robustness of the quality review processes should be stronger in terms of the type of evidence that is accepted as compliance – particularly with regard to individual staff responsibilities, including training, and facilities' professional/clinical resourcing (e.g. having an occupational therapist available in a RACF).

In the case of the Oakden facility in Adelaide, the South Australian Chief Psychiatrist's report noted that the facility was deemed compliant despite its unmet need for an occupational therapy service as part of the core establishment staffing profile. This gap in services meant expert input could not be consistently sought and provided.

OTA welcomes the commencement of the new single set of aged care quality standards from 1 July 2019, and supports its sharper focus on consumer choice and person-centred care. The Aged Care Quality Standards will help ensure enhanced quality of life for clients, as evidence-based care is too often neglected in favour of convenience-based care that meets the standards and is cheaper/easier to provide.

While the new standards have been expanded to cover a wider scope of care and service domains, OTA does not believe the standards alone provide sufficient clarity on the role of aged care providers in the provision of clinical care. Even when the standards are considered alongside the Quality of Care Principles, they lack sufficient clarity on the role of an aged care provider in the provision of clinical care, including allied health professionals.

Rewarding good practice in residential care and the sharing of this information by the Aged Care Quality and Safety Commission will be beneficial. Sanctions should remain for those facilities that do not comply with the Quality Standards and where serious risk of harm to consumers has been identified. The number of unplanned visits by quality assessors to facilities should be increased if there are complaints from a number of consumers about the same facility.

Given that staffing levels in RACFs are often insufficient to provide the minimum level of care required by residents, it follows that care drops below the minimum standards when any unplanned or unexpected issue arises (Harrington, Schnelle, McGregor, & Simmons, 2016).

***Recommendation: All staff who provide aged care services, including those who are contracted on an as-needs basis, should be required to have a baseline understanding of the Quality Standards for aged care, including person-centered care.***

***Recommendation: The robustness of quality review processes should be strengthened with regards to the type of evidence that is accepted as compliance, particularly with regards to demonstrating aspects related to individual staff responsibilities and professional/clinical resourcing. Some questions could be devised to elicit information that captures the reality of occupational therapy involvement in the broader aged care sector.***

## Complaints mechanisms

Older people in residential care are extremely vulnerable, and OTA is aware through anecdotal evidence that both they, and their relatives and support persons, can have no or limited awareness of existing complaints processes, or be reluctant to make complaints for fear that the older person at the centre of the complaint may become the target of ongoing intimidation. This perception has been corroborated by the evidence of witnesses to the Royal Commission.

Complaints systems must have built into them redress for any behaviour by a provider that pressures a resident, family member or significant other to withdraw a complaint. This needs to be achieved and managed via a shift in culture, and by the meaningful investigation of withdrawn complaints by the Aged Care Quality and Safety Commission.

There should be a culture of open disclosure and the respectful reporting of incidents, with a clear and accessible pathway of support to address occurrences. The education and training of all team members, and better-informed residents and families, should underpin a framework for continuous improvement.

## Chemical and physical restraint and the management of behaviours

OTA supports measures to minimise the use of restrictive practices and believes that a person-centred, individual approach to assessment and care planning should be taken when prescribing medications for the management of behaviours. In a person-centred care model, the person is provided with the care they need to meet their needs, rather than focusing on their condition.

Understanding the older person's needs and preferences, and identifying unmet needs such as pain, infection and incontinence, are essential to minimising levels of distress and Behavioural and Psychological Symptoms of Dementia (BPSD).

There is a need to improve the training and experience of care staff, as this is known to have a significant impact on how care is delivered, and the quality of that care.

OTA members report that while the majority of RACFs manage, handle and administer medications appropriately, problems around medication arise predominantly from insufficient staffing, lack of regular review, and excessive workloads. Poor working conditions lead to high staff turnover rates and the subsequent use of agency staff, particularly at night, and this is often the source of problems around medication.

Medication is sometimes prescribed on the basis of nursing reports, with the GP not always visiting the client prior to prescribing. OTA recommends that the strengthened regulatory approach adopted by the Australian Government be accompanied by supportive measures to assist providers and GPs. These measures could include:

- Access to education and training modules about the safe use of chemical restraint;
- Access to designated clinical experts to support aged care providers and GPs in the use of psychotropic medications;
- Increased engagement of community pharmacists to assist providers and GPs through the provision of information and alerts when these medications are prescribed and/or reviewing medications of older people; and
- Funding to support RACF providers in the cost of additional resources to implement non-pharmacological person-centered interventions to manage older people with dementia including occupational therapy intervention.

The impact of medication on older people is complex, due in large part to the risks associated with co-morbidities and the ageing process. Pharmacy medication review is rare in RACFs and it can be difficult to obtain the information required to support a recommendation to de-prescribe unnecessary or ineffective medications which are contributing to client risks such as falls and impaired cognition. OTA would support a multidisciplinary approach to medication management and suggests that this would be a sign of quality care (Olivieri-Mui, Devlin, Ochoa, Schenck, & Briesacher, 2018).

The management of client behaviour and the consideration of issues around medication are too often done by doctors and nurses in professional silos, with limited opportunity for multidisciplinary input to support non-pharmacological intervention. This is partly due to the outsource model by which the services of allied health professionals are obtained at many sites, and which are then restricted to very limited roles. By essentially devaluing the work of allied health professionals, RACFs limit their involvement in those initiatives which can improve the quality of care, such as environmental assessment and intervention, falls management, the creation of a meaningful routine and the facilitation of participation in the activities of everyday life. Too frequently the facility's focus is on pain management rather than holistic assessment and enhanced quality of care.

The non-pharmacological management of changed behaviours appears to be primarily led by allied health in many settings. Yet this is often the professional group most under-represented in RACFs. Significantly, a key recommendation of the South Australian Chief Psychiatrist's Oakden Review (Groves, Thomson, McKellar & Procter, 2017) was a much greater role for allied health in whatever facility replaces Oakden, including the services of occupational therapists.

*A Matter of Care,* the Report of the National Aged Care Workforce Taskforce (2018), states that allied health professionals such as occupational therapists "going forward…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). This is in line with the report's recommendation of reimaged and realigned aged care service provision in Australia, which includes a widespread review of the workforce across the industry, and aims to ensure that all older people, and particularly those in residential care, have access to holistic, multi-disciplinary care planning which includes:

- clinical needs;
- functional health;
- cognitive health;
- identity, cultural and diversity needs;
- living well;
- morning, afternoon, night-time and weekend care;
- advance care directives; and
- model rules (obligations of individual, family and aged care organisation) (p.43).

This kind of holistic care planning is a key skill of occupational therapists, who would be well placed to lead this work within the residential aged care sector and in aged care services generally. Commissioners can find the report here: https://agedcare.health.gov.au/sites/default/files/documents/09_2018/aged_care_workforce_strategy_report.pdf

OTA endorses the intent of changes around the use of physical and chemical restraints announced by the then Minister for Senior Australians and Aged Care, the Hon. Ken Wyatt AM MP, on 30 March 2019. OTA also welcomes the requirement that the use of physical restraint be included in the three quality indicators to be collected from all Commonwealth subsidised residential aged care providers.

***Recommendation: There should be timely and affordable access to allied health services for residential aged care residents, as this is essential to meeting clinical care needs, maintaining clinical safety and preventing presentations to emergency departments and admissions to hospital.***

A core consideration of the occupational therapist is the fit of the person to their environment, in order to facilitate participation in the everyday occupations of life. Occupational therapists are therefore well placed to provide assessment, recommendations and interventions that address the environments within residential aged care to support positive behaviour and the participation of

residents in everyday occupation.  This approach does not rely on the use of medication, but instead uses the environment to manage behaviour in a positive way (Altuntaş, Torpil & Uyanik, 2017).

De-prescription is uncommon in the mental health profession, although it is more frequently seen among geriatricians. It is regrettable that pharmacists who understand and specialise in this field are very rare. Older persons' mental health services require a more holistic approach to the client, in much the same way as other older persons' services do. The inclusion of geriatricians and specialist pharmacists in the multi-disciplinary team would be beneficial.

Sending clients to hospital to have issues addressed when behaviour becomes problematic, without first attempting to access behaviour management support services, is not uncommon. Currently, the use of medication to manage challenging behaviours is a more cost-effective strategy for RACFs, as the cost of medication and GP's services is borne by government and/or the client. In contrast, the non-pharmacological management of behaviours, or the implementation of new strategies, involves additional staffing costs which must be borne by the facility. There is something fundamentally wrong with an aged care system which penalises those facilities disinclined to keep their residents in a more or less permanently medicated state.

OTA also endorses recent calls for greater access to mental health care for those living in RACFs. Many residents are undergoing, or have recently undergone, a potentially traumatic change in their lives, transitioning from their home to a new and often uninviting environment. Often, this transition has been prompted by the death of a life partner. At such a time, access to the services of a mental health expert should be freely available.

The current situation, in which RACF residents cannot avail themselves of the *Better Access* items on the Medicare Benefits Schedule, is unacceptable.

***Recommendation: The auditing of RACFs should include auditing of the physical environment and its role in non-pharmacological management.***

***Recommendation: Geriatricians and specialist pharmacists should be included in multi-disciplinary aged care teams.***

***Recommendation: RACF residents should be able to avail themselves of the Better Access items on the Medicare Benefits Schedule.***

## Care of those Australians living with dementia

The non-pharmacological management of changed behaviours of those living with dementia is time consuming, and its assessment and implementation requires specific skills. Specialist services currently provide assessment and recommendations but personal care and nursing staff in RACFs are often undertrained to deliver interventions, as are many hospital staff.

Non-pharmacological management of changed behaviours in dementia is an emerging area, and time and resources should be invested in the professional development of those RACF staff working

in this field. It is unreasonable to expect nursing staff to attend training on managing changed behaviours and then disseminate it throughout a facility unless they have particular skills in this area of practice.

The physical environment plays a key role in the presence of changed behaviours for people with dementia. Time dimensions and the active use of space are essential for understanding and supporting the independence and wellbeing of ageing individuals (Kendig, 2003), and design of the physical environment is increasingly recognised as a vital intervention in supporting positive ageing and behaviour, particularly for those experiencing dementia (Day et al, 2000). Occupational therapists can and should play a vital part in the design of the physical environment to support residents with dementia (Nielson et al, 2018).

## Improving the quality of care provided to young people in RACFs

The issue of young people in residential aged care is of particular interest to OTA. Allied health professionals, including occupational therapists, can play a role in improving the quality of life of young people in RACFs by assisting them to maintain their independence. Young people in these facilities often experience social isolation as a result of being surrounded by people who are much older and who possess different care needs. The social activities offered by RACFs are also likely to be aimed at older residents, meaning younger people have limited opportunities to engage in activities that are meaningful to them.

Ideally of course, young people should not be in RACFs; they should be accommodated and cared for in purpose-built facilities designed to ensure they can strive for, and achieve, life goals.

However, if circumstances dictate young people be temporarily housed in RACFs, the Commonwealth Government should invest in upskilling and developing the professional carer workforce to ensure that RACF staff are able to provide the care and support these young people require through training in individualised supports and person-centred care.

OTA has developed the following workforce development proposal to enhance the quality of care provided to young people in RACFs. This proposal could fit within existing and evolving structures and frameworks.

**1. Long Term: Development and implementation of a Good Practice Framework**

This involves:

A. An assessment of best practice strategies around existing engagement of the workforce. This includes an assessment of where good things are happening – not just for older people with disability but for young people with disability. It also involves assessing what the workforce is doing well in these situations, what they are doing differently, and identifying what the enablers are that led to these positive outcomes.

B. This assessment of best practice would inform an enhanced set of standards for the accreditation process. Once these standards are designed, additional Commonwealth funding should be provided to develop training and workforce material to support RACFs to adopt the new framework. RACFs would have an incentive to meet additional standards through further funding opportunities for the training and ongoing development of all professional and non-professional aged care staff.

**2. Short Term: Assessment and management of the existing cohort of young people in RACFs and additional staff training needs**

This involves establishing a high level national NDIS residential care taskforce comprising experts in aged care, disability, nursing and allied health, as well as consumers and carers. The taskforce would be based on the work of the Senate Committee's first recommendation from the inquiry into young people in residential care – a national database to assess the scope of the problem of young people in RACFs (locations, numbers etc.) and have essentially three functions:

A. Make immediate recommendations about priority areas for consideration to improve social inclusion for young people in RACFs.

B. Identify the barriers to facilitating social inclusion in RACFs and advise as how these can be better managed.

C. Identify additional workforce training needs.

*Example – how this would work in practice:*

The nearest NDIS launch site to a cohort of RACFs would oversee an audit of facilities within a geographical area. Local Area Coordinators (LACs) would be tasked with screening and assessing issues at RACFs and engaging NDIS Planners where necessary to work with participants to develop plans for each participant in a RACF.

***Recommendation: Young people currently residing in RACFs should be accommodated and cared for in purpose-built facilities designed to ensure they can strive for, and achieve, life goals.***

***Recommendation: The Commonwealth Government should invest in upskilling the professional and non-professional aged care workforce in order to better respond to the needs of young people in RACFs and address shortcomings in the quality of care provided to this cohort. This should involve the development of a long-term Good Practice Framework to assess best practice strategies and inform an enhanced set of standards for the accreditation process. Additionally, a short-term measure could be the establishment of a high level NDIS residential care taskforce to assess the scope of the problem of young people in RACFs.***

## Home care – the way of the future

Amid the considerable publicity to date around the quality of residential aged care, OTA reminds the Commissioners of the importance of home care. Not only is this increasingly the preferred way to age for millions of Australians, as our population ages there simply will not be enough places in residential aged care facilities.

It is imperative, therefore, that governments ensure that the private homes in which we age are, to the greatest possible extent, fit for purpose and that the home care arrangements in support of those "ageing in place" are of the highest possible quality.

It remains a source of concern, therefore, that the assessment and initial development of care plans for the home care package recipient may not involve occupational therapy. The occupational therapist's functional home and environment assessment is the key opportunity to ensure people choosing to remain at home have the best prospect of maintaining independence, with the least possible reliance on paid/unpaid care services. Occupational therapists have the necessary training and skills to ensure that an elderly person's domestic environment 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).

There is currently no requirement to offer an aged care client access to an allied health professional under their home care package (HCP) funding. So, referral to an occupational therapist can be either:

- overlooked (in cases where the HCP provider does not have an in-house occupational therapist and they fail to consider the need for this service when planning how HCP funds will be used);
- avoided (in cases where the HCP provider does not have an in-house occupational therapist and they are reluctant to refer externally due to the cost involved. In other instances they may refer to an external occupational therapist but offer a level of payment which renders the service non-viable); or
- treated as a low priority due to the cost of allied health professionals being generally higher than the cost of nursing or carers. This jeopardises client care, safety and outcomes.

Furthermore, clients with HCP funding are often being asked by HCP providers to purchase their own assistive technology, using their HCP funding and without the advice of an allied health professional. Clients are therefore at risk of purchasing the wrong equipment, further jeopardising their health and safety.

Many of the following observations and recommendations are drawn from OTA's submission to the Commonwealth Government's inquiry: *'Future reform – an integrated care at home program to support older Australians'* (July 2017).

***Recommendation: Access to occupational therapy should be integral to Home Care Packages (HCPs) as well as through the Commonwealth Home Support Programme (CHSP).***

**Current home care arrangements**

The current state of home care is confused and poorly targeted.

Roll out of the *Increasing Choice in Home Care* reforms and the consequent release of HCPs into the aged care system created confusion for most consumers and their representatives. The Commonwealth received considerable unfavourable feedback about the correspondence sent to consumers advising of the allocation of HCPs. Assessor and carer service staff have spent considerable face-to-face time with consumers, explaining this correspondence and advising on how to choose a HCP provider. Many consumers did not know that they were in the national queue and could not remember having undergone an Aged Care Assessment Team (ACAT) assessment. These were consumers who had read the correspondence and contacted My Aged Care. The contact centre staff then issued a Regional Assessment Service (RAS) assessment in response to the consumer's call. Vulnerable consumers who did not read or understand their letters experienced the loss of their allocated HCPs. The *Increasing Choice* reforms cannot succeed until there is capacity in the system to educate consumers and facilitate their "choosing".

Another issue that has increased the workload of assessors is the increased number of priority changes. Priority changes relate to the urgency of the application, with a higher priority gaining access to an HCP before a lower priority. Priority changes are often sought by consumers and providers of HCPs, due to the long waiting times for a package.

ACATs previously helped consumers to access HCPs by negotiating with providers, especially with regard to urgent cases, but are now unable to predict when a package will become available. Having a simple notification email from My Aged Care when an HCP becomes available would enable ACAT staff to better assist consumers.

Clients are sometimes discharged from hospital on the understanding that necessary services will be in place in their home, only to find that while a service provider has been engaged no services are in fact in place.

Some OTA members report that the provision of services is slower now than previously.

Consideration should be given to a "trial" period with a service provider before the client enters into a service agreement and is liable for exit fees if he or she wants to change service provider. Exit fees are particularly problematic in the transient populations of remote communities.

The automatic upgrade of consumers to a Level 4 Package where a pre-existing approval exists is proving problematic as some providers do not have the capacity to provide this level of service (and may be the only service provider a consumer has access to). There should be a formal acceptance mechanism attached to upgrades.

Not enough importance is attached to the concept of reablement. While this takes time initially, it has the potential to save time and money in the future. The extent to which reablement is actively pursued depends on the service provider staff and on the culture of the organisation. OTA is of the

view that aged care assessment processes should include assessment of the potential for reablement of the individual in his or her home.

As in all areas of aged care, the delivery of home care should be underpinned by an ongoing commitment to the training of the workforce. Aged care workers should be team-based, with occupational therapists available to provide input to these teams.

Any new home care arrangements must address the individual's need for social contact. This might involve drawing the individual's attention to local opportunities for such contact; for example, some OTA members report that Men's Sheds are proving a popular meeting place for consumers in rural towns.

Generally speaking, however, OTA members welcome the introduction of Consumer Directed Care and the removal of Aged Care Approvals Round (ACAR) funding rounds but ask that waiting times for HCPs be available to assessors and clients so that informed decisions can be made around their future needs.

***Recommendation: There should be a simple routine notification email from My Aged Care when a Home Care Package becomes available, thereby enabling ACAT staff to better assist consumers.***

***Recommendation: Consideration should be given to a "trial" period with a service provider before the client enters into a service agreement and is liable for exit fees if he or she wants to change service provider.***

***Recommendation: There should be a formal acceptance mechanism attached to HCP upgrades.***

***Recommendation: Aged care workers should be team-based, with occupational therapists available to provide input to these teams.***

**Policy objectives**

There are currently a number of disconnects undermining government reform policy. The ability to deliver the right services to the right cohort at the right time is not possible in a CHSP system that is not yet sufficiently funded to deliver a response to an independent assessment. The current model of independent assessment of need, separate from service provision, is occurring in a constrained service delivery environment where there are no basic services available to support a CHSP consumer once assessment has occurred. This is confusing for consumers and time intensive for RAS assessors who are continually monitoring service availability and re-referring past assessments. This contradicts the principle of the RAS being an "assessment" agency. The RAS is also required now to case manage and coordinate services.

As part of the My Aged Care co-design workshops, the issue of home modifications and occupational therapy assessments was identified as one needing improvement. This has not yet been achieved and is still causing problems for consumers, occupational therapists and home modifications providers. Equipment provision is still a problem, with inequity across jurisdictions. If the consumer is receiving a HCP or CHSP service, the availability of funds for equipment is severely limited.

A significant increase in funding for simple supports such as domestic assistance is required. The lack of available services impacts on the ability to promote wellness and reablement through occupational therapy and other allied health services. A consumer who is willing and able to benefit from a reablement approach will continue to decline functionally while waiting for services to become available. OTA cautiously welcomes the current RAS reablement trial, which should assist in promoting wellness and reablement as part of the assessment process, although we would like to emphasise the role of occupational therapists, who have expertise in function, activities of daily living, modifications to the home and environment, and in equipment that enables participation in the usual tasks of daily living, and who could ensure that such equipment is well used in the trial.

HCPs need to be increased across funding bands so that consumers can receive the right level of care when they need it. Currently, consumers are accepting lower level HCPs and expecting the CHSP system to "top up" their level of care. The CHSP services required to top up an HCP predominantly involve domestic assistance, transport and personal care. This reduces the availability of CHSP services for consumers who are functioning at a higher level and only require a basic level of service to maintain their independence.

Another issue of concern is the cost of the HCPs as opposed to the minimal or no cost of a CHSP service. Consumers would rather remain on CHSP services than accept a level 1 or 2 package which requires means testing and a substantial contribution from their pension. Mandated fees for CHSP services would assist, but a variable contribution for HCPs based on the level of the package might also assist.

Greater support for consumers who are unable to navigate the system independently and require advocacy and case management is also needed. OTA therefore supports the current trial of the Navigators being carried out by COTA.

Privately engaged service providers, especially those providing domestic assistance, perform a vital role in keeping individuals out of care. They are often seen to be cheaper, especially for self-funded retirees, more caring and more flexible than some CHSP funded service providers. In some cases, long term cleaners' transition into caring/support roles, at the request of a client who may be perfectly happy with this arrangement or may be unaware of other options. Having information on these non-government funded services on the My Aged Care website would assist consumers in making this choice.

**Minimising red tape**

The success of the policy objective to minimise red tape and unnecessary regulation can only be credibly measured if accompanied by the objective of greater transparency for the consumer. Greater transparency should include the Commonwealth's sharing of information from and between Aged Care and the NDIS, particularly with regard to those Indigenous people aged between 50 and 64 who develop a disability and may be eligible to switch to NDIS supports.

Minimising red tape needs to be an objective aimed at benefiting both the consumer and the provider. Currently, red tape is restricting both the extent and quality of service uptake. RAS and ACAT should sit under Health in all jurisdictions to ensure a strong connection between services. Access to quality allied health professionals – for purposes of assessment, intervention, timely follow-up inclusive of assessment, and prescription of assistive technologies – needs to be facilitated.

**Improving assessment**

An integrated assessment model would assist the consumer in navigating what is currently a confusing system (Ivanoff et al, 2018). In New South Wales, the amalgamation of the management of the ACAT and RAS services for some teams does assist in integrating the assessment process, reducing duplication. What has made the system very confusing is having more than one RAS in each Local Health District.

Having clearer policies and procedures would also assist. There also needs to be greater integration with health services, including geriatric services, GPs, occupational therapists and other health professionals, as well as hospitals that carry out assessment services (Dickson & Toto, 2018).

OTA proposes the following changes to the RAS:

- Allow RAS assessors to perform hospital assessments prior to discharge to allow for discharge services;
- Decrease the need for further assessment by the RAS when extra services are required (e.g. cleaning or day therapy), as currently the RAS has to visit the consumer again in order to approve additional services as part of a support plan review; and
- Remove the need for an RAS assessment for some services and allow referrals directly from the My Aged Care contact centre. These services could include:

    - Day therapy access (another assessment is currently required).
    - Home modifications, when an occupational therapist has already assessed what is needed.
    - Meal services for delivered meals.
    - Leisure groups.

ACAT should have the delegated authority to complete basic assessments in those geographical areas where access to RAS is difficult. A basic assessment should be introduced for Aboriginal and Torres Strait Islander flexi care acceptance, to ensure consistency in eligibility requirements. In remote areas non-ACAT trained allied health professionals should complete the face to face component of the holistic assessment, with support from ACAT and RAS ‘champions’ to input the data into the system and case conference the delegation decision under the Act.

Phone based screening should cease.

There should be a reduced focus and less emphasis on assessment KPIs, and greater scrutiny of, and investment in, the quality of outcomes for consumers.

**Home Care Package levels**

The reluctance of consumers to accept level 1 and 2 HCPs indicates that consumers believe these packages do not deliver value for money in comparison to CHSP services. The transition of CHSP funding to level 1 and 2 HCPs would create a more transparent system. Additionally, changing the fee structure for lower level HCPs to a lower rate that is equal to the package provided would assist in this process. Questions have been raised about whether level 1 packages are required, given the similarities with CHSP services. Some OTA members have suggested changes could be made at this lower end in order to support higher level packages.

Introducing a higher HCP (level 5) by reducing the number of level 2 packages would assist those consumers who have highly complex needs, including palliative care, preventing admission to a residential aged care facility.

OTA acknowledges that it would be costly to provide HCPs at a higher level, as there are no cost savings associated with this (as when people are forced to enter a residential aged care facility). One option could be to increase the number of level 3 and 4 packages and allow consumers to access these on an as needs basis. Consumers should also be allowed to move to a lower package if their condition or circumstances improve.

To a certain extent, providers and provider organisations should be guided by the views of consumers and consumer groups. What the consumer wants should determine best practice and how best to meet this stated need. For example, would consumers prefer to remain in their homes with a higher-level package or move to a residential aged care facility?

Consideration could also be given to providing services to clients in a day therapy centre setting as opposed to individual funded services, with clients having a choice of how they would like their services delivered – either at home or centre based.

A higher package level would be particularly useful for those who require specialised and custom equipment which, while very costly, reduces day to day care needs.

***Recommendation: Consideration should be given to providing services to home care clients in a day therapy centre setting as opposed to individual funded services, with clients having a choice of how they would like their services delivered – either at home or centre based.***

**Possible funding models**

Level 1 and 2 HCPs combined with CHSP funds would provide greater flexibility, increased choice and improved outcomes for consumers with lower level needs. The notion of vouchers provided by the CHSP system alongside HCPs would deliver benefits in terms of flexibility, particularly for consumers with non-episodic needs. However, the voucher system would also be problematic in remote areas where there is nothing to 'shop around' for, and the concept of a voucher with monetary value has unfortunate social implications for vulnerable clients.

Currently, the inability to progress wellness and enablement is due to a service system that has been built on an output basis and has a task focus, and which does not allow providers flexibility in service provision.

Block funding works well for short term services and low-level services, such as transport and cleaning/domestic care. Community transport and delivered meals need to remain block funded, as these services are cost prohibitive in an open market. Community transport needs to be block funded and generic across all program areas.

Home modifications also need to be block funded, however there needs to be an emphasis on promoting independence and reducing the consumer's reliance on services as a result of the modifications. It is also worth noting that under block funding it would be easy to operate a system in which assistive equipment is provided on a loan basis and subsequently reused by others. The Commonwealth could contract the state-based equipment schemes to provide assistive equipment on an equitable basis, reducing the variability of the schemes across Australia.

Individualised funding may work well for larger items of assistive technology and more complex home modifications, however there does need to be an equipment pool that consumers can access in the short-term until their package becomes available.

The removal of block funding in remote areas, where the population fluctuates and workers are difficult to attract and retain, would prove detrimental to the interests of consumers. While block funding in remote areas maximises cost efficient service delivery, these services must be easily accessible and unburdened by 'red tape' around eligibility. An example of where this worked well is the block funded CHSP Troopy Program in the Northern Territory, which offered services to clients and carers in remote bush camps. The introduction of individualised funding has rendered this service difficult to access for HCP clients.

**Assessment and referral for services**

A focus on the client's capacity for wellness and reablement should be evident in every assessment process. The CHSP's emphasis on the provision of ongoing services needs to change; rather, providers need to support the consumer's independence and lessen their reliance on ongoing services.

Flexibility of funding is essential to the development of a wellness and reablement model. Currently, there seems to be little consistency as to who does and who does not receive reablement support under the various programs available. Those that do not actively seek support tend not to receive it, despite sometimes obvious need. There is a need for more in-home Short-term Restorative Care (STRC) packages, with less rigid guidelines. For example, if you have been hospitalised in the 3 months before your assessment you can be excluded from accessing STRC.

OTA endorses the National Aged Care Alliance's call for all HCPs, including level 1 packages, to include an STRC program (i.e. regular therapy) where appropriate.

Clients should be able to receive short-term services with a referral from a GP or allied health professional/nurse and then be assessed for longer term services. This would enable them to access services more quickly and facilitate responsible discharge from hospital. These short-term services could last just six weeks and during that time an RAS assessment for longer term services could be conducted, if necessary. During this period allied health services should be offered, in order to assess and optimise the likelihood of previous levels of functioning being attained.

Short-term intensive restorative/reablement interventions prior to the assessment for ongoing support may be beneficial from a financial point of view but the client's medical conditions, both chronic and episodic, and long-term needs would have to be considered before this approach is recommended.

Consumers should only receive a reablement assessment first if the need is identified (i.e. Transitional Care Programme (TCP) or STRC. To improve this process the assessor completing the reablement assessment should also complete the assessment required for ongoing support, thereby reducing the consumer's need to tell their story multiple times, and speeding up the assessment process after the period of reablement.

***Recommendation: All HCPs, including level 1 packages, should include a tailored restorative care or reablement program prior to the provision of ongoing regular services. This type of program should not impact on the provision of responsive services that are required for interim care needs.***

***Recommendation: Home care clients should be able to receive short-term services with a referral from a GP or allied health professional/nurse and then be assessed for longer term services.***

**Ensuring services are responsive to consumer needs and maximise independence**
Service redesign of the CHSP to include greater consumer monitoring activities could maximise independent living. Afternoon 'turn down and lock up' services or other forms of drop-in support on a daily basis would be useful, especially for consumers with dementia (Bracken-Scally et al, 2018). Evening and weekend services would provide greater security for vulnerable consumers, however these are currently not available.

The provision of funding for ongoing home maintenance and lawn mowing is an area that could be reviewed and evaluated for its contribution to enabling ageing in place. It should not be funded by government unless it is a one-off service to reduce a safety risk.

It is important to ensure assistive equipment needs are being met, particularly for people with higher needs and palliative care. Some equipment is too costly to provide through packages, particularly for those clients with high care needs who cannot reduce these to offset equipment costs. This is regrettable, as equipment can enable people to be more independent and remain at home longer (Scott, Callisaya, Duque, Ebeling & Scott, 2018).

Prescription and provision of assistive technology and home modifications is an important part of clinical care, undertaken by skilled professional staff such as occupational therapists, and should be included under clinical care in the new standards. Lack of assistive technology and home

modifications, or the inappropriate prescription of such technology, can present clinical risks to the client, including falls and pressure injuries (Gray-Miceli, Rogowski & Ratcliffe, 2018).

OTA recommends that providers be required to adopt a consistent approach to the prescription, provision and maintenance of assistive technology and home modifications, and that an occupational therapist carry out the assessment for the most appropriate equipment.

Consideration should be given to Goal Attainment Scales pre and post intervention (Lyons et al, 2018), particularly for re-enablement programs or transitional care. Similarly, KPIs and performance measures based on client's functional improvements would facilitate the assessment of an intervention's effectiveness.

Providers need to be audited to produce Consumer Directed Care (CDC) care plans and this should be reviewed against a client's original ACAT assessment. Despite consumers being very goal directed and innovative in what they would like from a package of care, providers continue to offer just the same traditional services (meals, transport, laundry). More workshops and information need to be provided to providers to upskill them in the delivery of CDC Packages.

**Accessing services under different programs**

Allowing some consumers to access both programs does promote inequity. However, until the waiting times for packages are reduced, this will have to continue so consumers receive the services they need in a timely manner.

Until an integrated care at home program is introduced, there could be more clearly defined or limited circumstances in which a person receiving services through an HCP can access additional support through the CHSP. This can be achieved by providing time limited CHSP services while waiting for a package.

**Supporting specific population groups**

Culturally and linguistically diverse (CALD) and Aboriginal and Torres Strait Islander consumers require flexible approaches in support delivery. Culturally specific HCP providers may not be funded to provide the full range or levels of HCP care and, accordingly, there needs to be the flexibility to engage multiple providers.

Providers need support and case studies to educate them as to what CDC means and how it can be applied creatively by Aboriginal and Torres Strait Islander populations, especially those in remote areas who have access to only one provider. Many remote Aboriginal and Torres Strait Islander clients have creative goals and services they want which are cost effective to run and access, but providers remain 'stuck' in their thinking and only provide set CHSP services. Many remote providers are managing block funded CDC, HCP individualised and NDIS individualised services, and this considerable administrative burden detracts from their capacity to deliver services well (Czaja, Boot, Charness & Rogers, 2019).

CHSP participants should not be disadvantaged when moving to the HCP program – at present when CHSP recipients, who have enjoyed entry level services (such as a fortnightly domestic service and

attending a day care centre once or twice a week) move to a HCP service due to increased needs, the HCP funds are not adequate to cover the level of service they received under CHSP as well as the additional services they need. This can result in a recipient having to give up attending the day care centre – a social experience that aids wellness – in order to pay for the increased 'at home' personal care and other services needed to meet their increased requirements.

**Consumers who may require additional support**

The introduction of an assigned case manager who acts as an independent advocate on behalf of the vulnerable consumer would facilitate the establishment of HCPs, and would enable the monitoring of the consumer on an ad hoc basis. The case manager could also assist in negotiating changes to care plans or in identifying the need for higher levels of care.

In addition to helping consumers navigate the system, these independent advocates could help put services in place once assessments have occurred. They could explain the costs and requirements of aged care services, advocate for the prudent use of funds (e.g. the purchase of appropriately prescribed assistive technology and home modifications, the engagement of allied health services). The attendant reduction in risks around the home and improvements to the client's functionality would offset some of the costs of such case managers/advocates.

***Recommendation: There should be assigned case managers to act as independent advocates on behalf of the consumer, facilitating the establishment of HCPs and enabling the monitoring of the consumer on a periodic basis. The case manager could also assist in negotiating changes to care plans or in identifying the need for higher levels of care.***

**Structural reforms**

The IT associated with My Aged Care, and its interface with other systems, remains a problem for clients and their providers. Other health services, including occupational therapists and other health professionals not funded by the CHSP, should be added to the service provider portal and the My Aged Care system.

Similarly, the Carer Gateway is difficult to navigate and also requires the user to have access to the internet.

**Informal carers**

Providing more in-home respite, residential respite, education for carers and services specialising in carer support would be of value (Lethin et al, 2019).

Respite for informal carers is a major need across many remote communities. Carers, or the people for whom they care, have to travel long distances and at considerable expense to access this respite care. Currently these travel costs are not, or are inadequately, subsidised. Without effective arrangements for respite care, consumers can find themselves prematurely in need of residential placement. The cost of access to respite services in remote areas needs to be factored into any new arrangements.

**Technology and innovation**
The provision of assistive technology in the home promotes independence and enables older Australians to remain living at home for longer. A trial in an area/s could be beneficial.

For example, as part of the roll out of the NBN, the Illawarra was given funds to monitor consumers with a chronic illness using telehealth monitoring in the home. This model and technology proved very successful and could be used for consumers living alone and considered at risk. It could include, for example, falls monitoring and voice activation of devices.

Assessment by an occupational therapist prior to a client going on to an HCP or accessing services would ensure the client's awareness of the role appropriate assistive technology can play in enabling them to live independently for longer in their own homes and in reducing their need for supports. Partnering with seniors' groups such as COTA could help drive this awareness by providing accessible information to older Australians.

Inconsistency of access to assistive technology and home modifications across the country remains a real concern; it is a postcode-based inequity that severely compromises some Australians' quality of life.

**Home modifications**
OTA is concerned that some home modification services close their books for several months of the year once available funds have been expended. This places elderly people at significant risk for prolonged periods of time. No community should place its elderly citizens at risk by allowing budgetary considerations to outweigh clinically determined need.

There needs to be better Commonwealth guidelines with regard to reasonable and necessary home modifications and assistive technology. The needs of the client should be assessed and met within reason; there should be controls in place to ensure the need for home modifications does not become the pretext for lavish renovations.

***Recommendation: The Commonwealth needs to develop and disseminate guidelines with regard to reasonable and necessary home modifications and assistive technology.***

**Rural and Remote areas**
Consultation with local communities on what works, or might work, in their location is essential. Increased use of telehealth and videoconferencing for assessments would be useful (Marx et al., 2019).

Service providers need to be properly subsidised for the travel expenses and, where applicable, the accommodation costs, they incur.

A genuine commitment to rural and remote services will help prevent the situation where a client has to move from the farm to the town in order to access services, often into an RACF prematurely. As indicated earlier, the Northern Territory's Troopy program could serve as a useful model for remote services.

Leveraging off health services that already visit remote communities could enable the provision of innovative aged care services, with economies of scale. Physiotherapists and occupational therapists who visit existing health clinics could run group programs at day respite centres with block funding. They could also conduct aged care assessments.

A review of the Flexi-care programs should be undertaken to determine their effectiveness.

***Recommendation: There needs to be a genuine commitment to rural and remote home care services, including increased use of telehealth and videoconferencing for assessments, and properly subsidised travel expenses and, where applicable, accommodation costs for service providers. Leveraging off health services that already visit remote communities could enable the provision of innovative aged care services, with economies of scale.***

**Regulation**

There needs to be more sharing of information between providers/assessors on innovative models and practice. A trial of different models, especially in rural and remote areas, should also be carried out.

Having greater flexibility with funding (especially CHSP funds) would allow for more individually tailored programs to be provided to clients rather than just one service type.

Governments should ensure that all Commonwealth and state/territory programs have the same or similar quality and standards requirements, so that providers do not have to comply with multiple frameworks. In remote areas it is common for the same provider to service NDIS clients as well as HCP recipients. The multiple reporting and auditing frameworks with which they need to comply are complicated and time consuming. This is a major disincentive to working in areas where there is the greatest need for health professionals.

***Recommendation: Governments should ensure that all Commonwealth and state/territory programs have the same or similar quality and standards requirements, so that providers do not have to comply with multiple frameworks.***

**Aged care and health systems**

There is duplication in the types of health services provided by the states and territories and the Commonwealth's aged care system. In the health system, there are multiple hospital avoidance services to prevent hospitalisations, including allied health and nursing services. These services do not link with aged care services unless funded by the CHSP. The IT systems are not linked, so that health staff need to use an electronic medical record but also complete the National Screening and Assessment Form (NSAF) in a different system. A long-term IT solution so that these systems interface would clearly be beneficial.

Outpatient and domiciliary occupational therapy services are linked to hospital services but carry out the same services as CHSP occupational therapists. The acute geriatric services and clinics link with GPs, but not the aged care system.

There needs to be more case coordination of complex consumers to navigate available services. This has to be at a local level because local knowledge is vitally useful. The expansion of the My Aged Care portal to include services not funded by HCPs or the CHSP would assist consumers to identify available services. The cost of services also needs to be included, rather than just the exit fees for HCPs. There needs to be increased cooperation between services rather than competition, which recent reforms seem to have promoted.

Currently, there are gaps in the system for consumers with age-related chronic conditions but who are aged under 65 years. They do not qualify for the NDIS or the CHSP. An example of this is consumers with early onset dementia. There needs to be flexibility in the system to allow these consumers to access funding for aged care services.

There is duplication for the client cohort of 50-64 year old Indigenous Australians who may have been accessing aged care services, but then encounter a disability, making them NDIS eligible. There is another gap in care for people who palliate quickly. Palliative care does not include home care structures or supports; too often consumers die before they can receive the care they need in order to be properly supported and comforted at home.

***Recommendation: The My Aged Care portal should be expanded to include services not funded by HCPs or the CHSP, assisting consumers to identify available services.***

## Falls Prevention

As more Australians elect, or are required, to age in their own homes, it is imperative that governments ensure these homes are as safe and senior-friendly as they can be.

In particular, every dollar that individuals, private health funds or governments invest in falls prevention will save our health system multiple dollars, as well as vastly improving the quality of life of elderly Australians and relieving pressure on an already overstretched health system.

As OTA noted in its 2018-19 pre-Budget submission to 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.*

There is ample evidence to support the assertion that every dollar invested in falls prevention will save multiple dollars:

- Hip fracture rates are showing some reduction worldwide yet hospitalisation rates for falls are not abating with significant increases over the past decade (Australian Institute of Health and Welfare [AIHW], 2012);

- These national increases are for both men and women and the highest (2.1%) are for those aged 85 years and over (Australian Institute of Health and Welfare [AIHW], 2012);
- The mean cost of health care for an injurious fall, a common occurrence, was estimated, in 2008, to be between $6,600 and $18,600 for those admitted to hospital (Watson, Clapperton & Mitchell, 2010);
- One in every 10 days spent in hospital by a person aged 65 and older in 2009-10 was directly attributable to an injurious fall (1.3 million patient days over the year), and the average total length of stay per fall injury case was estimated to be 15.5 days (Australian Institute of Health and Welfare [AIHW], 2013);
- A meta-analysis of randomised trials of environmental interventions found a significant reduction in the risk of falling of 21% for all six trials (n=3,298) RR=0.79 (CI: 65 to 0.97). Highest effects were with a sub group of people at high risk of falls (RR = 0.61 CI: 0.47 to 0.79) (Clemson, Mackenzie, Ballinger, Close, & Cumming, 2008);
- Most effective interventions were led by occupational therapists (Clemson, Mackenzie , Ballinger, Close, & Cumming, 2008);
- Home modifications to prevent falls are cost effective (Wilson, Kvizhinadze, Pega, Nair, & Blakely, 2017; Keall, Pierse, Howden-Chapman, Guria, Cunningham, & Baker, 2017); and
- Compared to other falls prevention interventions; home modifications are the most cost effective (Frick, Kung, Parrish, & Narrett, 2010).

Accordingly, the Commonwealth should develop and lead the implementation of a nationwide falls prevention strategy, aimed at ensuring Australians' homes are as safe and senior-friendly as they can be. Working with regulators and industry bodies, the Commonwealth should develop guidelines to ensure that all future dwellings include basic falls prevention features, or have scope for the addition of falls prevention features.

***Recommendation: The Commonwealth should develop and lead the implementation of a nationwide falls prevention strategy, aimed at ensuring Australians' homes are as safe and senior-friendly as they can be. Working with regulators and industry bodies, the Commonwealth should develop guidelines to ensure that all future dwellings include basic falls prevention features, or have scope for the addition of falls prevention features.***

## Conclusion

OTA believes that an enlightened aged care system is one established firmly on an evidence base. It should be properly monitored and regularly audited, with the collection and assessment of data driving this process. Those providers unwilling to collect and share data should simply cease being providers.

Overworked RACF staff with insufficient time to deliver optimal care, and the lack of any active management of staff culture by RACF leadership, is likely to lead to compassion fatigue, the depersonalisation of clients and an increased reliance on pharmacological management.

OTA believes that the very opposite of this downward spiral should be the aim of our aged care system. There should be incentives in place to encourage the non-pharmacological management of behaviours of concern. There should be an emphasis on multi-disciplinary teamwork, skills development and innovation.

Occupational therapists in residential aged care, for example, are currently a wasted resource. Rather than being limited to the role of pain management, they should be allowed and encouraged to bring the full range of their expertise to the task of caring for, and promoting wellbeing in, our elderly population.

And, perhaps most importantly, positive client care should be sustainable. The structure and funding of our aged care system should be such that those RACFs delivering genuinely compassionate and innovative care can do so profitably.

It is the view of OTA that our aged care system is intrinsically flawed. It entrenches outdated practices which depersonalise the client, and financially penalise innovative client-centred approaches to care. New aged care standards, underpinned by a funding instrument which encourages and rewards an emphasis on clients' meaningful activity and independence, are long overdue.

It is the recommendation of OTA that residential aged care facilities be subject to the highest and most rigorous standards of accreditation available, such as those that govern health care environments, including robust processes for the management of complaints.

And, as millions of Australians age in their own homes, it is imperative that these homes be built or modified to ensure these individuals age as safely and comfortably as possible. Falls prevention should rank alongside road safety and obesity in the national consciousness.

It is also of paramount importance that people ageing in place have access to timely, person-centred and culturally appropriate care delivered by a properly trained workforce. This should be achieved by means of a well-funded system of graded home care packages, in which the individual can move quickly and easily between packages as their condition changes.

OTA draws the Commissioners' attention to the important work of the National Aged Care Alliance (NACA), of which OTA is an active member. OTA strongly endorses NACA's views on the Aged Care Funding Instrument and urges Commissioners to read its position paper on Home Care Funding Packages, due for completion in September of this year.

Finally, OTA draws the Commissioners' attention to two case studies at Appendix A.

OTA thanks the Commissioners for the opportunity to make this submission.

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## Appendix A
## Occupational therapists – a wasted resource.
## Case studies.

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.

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 able to assess changes in a person's functional capacity and promote reablement. 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.

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.

**Case Study One**

*I am an occupational therapist that has worked in numerous aged care homes with a few different aged care providers. I graduated from the University of Queensland with First Class Honours in 2003.*

*The 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 wheel chair 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 registered with APHRA. 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 on Autumn Care. 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 I thought that lying on documentation was breaking the law. I am told to do this over and over and over again. This feels unethical.*

*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*
- *Pain management.*

*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 the aged care profession 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 Two**

*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 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.*

*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.*

*Nurses need 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.*

*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.*