PARLIAMENT OF AUSTRALIA

STANDING COMMITTEE ON HEALTH, AGED CARE AND SPORT

INQUIRY INTO THE QUALITY OF CARE IN RESIDENTIAL AGED CARE FACILITIES IN AUSTRALIA

OCCUPATIONAL THERAPY AUSTRALIA (OTA) SUBMISSION

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Introduction

Occupational Therapy Australia (OTA) welcomes the opportunity to provide a submission to the Standing Committee on Health, Aged Care and Sport as part of its Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia.

Occupational Therapy Australia is the professional association and peak representative body for occupational therapists in Australia. As of December 2017 there were more than 19,500 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.

In August 2017, OTA provided a submission to the Senate Community Affairs References Committee's inquiry into the effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised. While compiling this submission, OTA consulted with occupational therapists who were either currently working, or had worked, in residential aged care facilities (RACFs). A number of therapists had become disillusioned with these facilities due to the extremely poor standard of care provided to clients. 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.

It is clear that RACFs are not intended to be rehabilitation facilities. Residents are not expected to 'get better', and their ongoing need for care is what enables these facilities to keep receiving funding. This overriding mentality may have led some to believe that it is not worth devoting too much attention to residents' needs. While OTA acknowledges that nursing home residents generally require a higher level of care than older people living in the community, the expectation that they will not recover can compromise the quality of care they receive.

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.

Summary of recommendations

- A coordinated approach to preventing and responding to elder abuse should be developed at a national level and led by an interagency taskforce.
- Primary Health Networks (PHNs) should work to educate the community about elder abuse in the health, disability and aged care sectors, and develop resources to assist staff in RACFs to identify common signs of abuse.

- States and territories should enact mandatory reporting legislation that requires health professionals to report serious cases of elder abuse to authorities.
- Video surveillance should be allowed in private rooms of RACFs with the permission of residents or their families and guardians.
- All aged care facilities should be required to publicly display a notice on how to report complaints.
- 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 RACFs.
- 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.
- Provision of assistive equipment in RACFs should be overseen by a suitably trained occupational therapist who can assess the functional needs of residents.
- New graduates working in aged care should be required to undergo a structured work placement and meet regularly with a supervisor who can assess their progress.
- Staff in all aged care organisations should be funded to complete refresher training through online learning modules to ensure that their skills and experience remain up to date.
- Direct care service providers should receive mandatory training in trauma informed care to enhance their ability to identify and respond to signs of elder abuse.
- All staff who provide services in RACFs, including those who are contracted on an as-needs basis, should be required to have a baseline understanding of the new Aged Care Quality Standards which will take effect from 1 July 2018.
- The robustness of accreditation review processes should be strengthened with regards to the type of evidence that is accepted as compliance.
- Sanctions should apply to facilities that do not comply with the Quality Standards where possible serious risk of harm to consumers has been identified, while the number of visits by the Australian Aged Care Quality Agency to facilities should be increased if there are multiple complaints about the same facility.
- The self-assessment and site audit that form part of the current accreditation process should be maintained, however there should be a greater emphasis on the perspectives of consumers and their representatives with regards to quality of care.
- Aged care organisations should be required to clearly specify the duties and responsibilities involved in any positions they advertise. Additionally, any false claims regarding the chance to gain experience in a particular area should be thoroughly investigated by the relevant authority.
- Interventions and modalities funded under the ACFI should be expanded to take into account the broad scope of occupational therapy practice.
- Aged care organisations should be required to invest in consumer-focused aged care teams that include allied health professionals such as occupational therapists.
- 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.

The role of occupational therapists in aged care

Occupational therapists play a key role in providing aged care services to older people, both in RACFs and in the community. These include:

- A range of interventions to enhance wellbeing and preserve, restore and enable functional outcomes;
- Assessing and modifying clients' home and community environments to enable them to remain living at home for longer and to participate in everyday activities;
- Prescribing equipment to assist with mobility and everyday living (shower rails, wheelchairs etc.);
- Prescribing a range of adaptive strategies and providing education and advice to improve people's mobility and function, such as joint protection techniques and work/rest routines for daily living;
- Prevention, assessment and management of chronic disease and injuries – for example, identifying the risk of falls in the home; and
- Mental health and wellbeing services specific to ageing and environment.

OTA is committed to increasing the number of occupational therapists working in aged care, particularly as demand for aged care workers will inevitably increase in the coming years as a result of an ageing population.

A table outlining the types of interventions that occupational therapists can provide in residential aged care is provided at the conclusion of this submission under Appendix A.

Elder abuse in residential aged care facilities

Despite the nationalisation of aged care services, Australia does not have a national strategy to deal with elder abuse. Although there has been growing media coverage of elder abuse, particularly in RACFs, it has not been given the same level of attention as other serious issues such as domestic violence. For example, the COAG Advisory Panel on Reducing Violence against Women and their Children was established in April 2015 to address the growing prevalence of violence against women and their families. OTA believes that elder abuse similarly needs to be elevated as a policy priority at a national level.

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 state are able to access. We unreservedly endorse the Australian Law Reform Commission's recommendation that the Australian Government, in cooperation with state and territory governments, develop a National Plan to combat elder abuse.

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. The ACT Elder Abuse Prevention Pathways flowchart is available at http://www.communityservices.act.gov.au/__data/assets/pdf_file/0006/317607/Elder-Abuse-Prevention-Pathways-May-2012.pdf;
- 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.

Recommendation 1: A coordinated approach to preventing and responding to elder abuse 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 2: Primary Health Networks (PHNs) should work to educate the community about elder abuse in the health, disability and aged care sectors, and develop resources to assist staff in RACFs to identify common signs of abuse.

Examples of elder abuse/mistreatment of older people in RACFs

- An occupational therapist visiting a nursing home was asked to leave the room while their patient was transferred from bed to wheelchair. The occupational therapist overheard the patient being verbally abused and insulted by a male attendant and his partner did not say anything. Often family members of elderly nursing home residents are afraid to report cases of elder abuse for fear of how their parent/relative will be treated in future.
- A veteran who had suffered a dense stroke had a leg amputated due to poor nursing care. His remaining leg is now developing a contracture as a result of irregular therapy. Many aged care facilities are short staffed and residents often develop pressure sores as a result of neglect.

- 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 are forced to 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 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. Diversional programs offered by RACFs often involve craft-based activities that are not adapted to residents' different levels of need. When families pay for services privately, there is much more scope to tailor programs to residents' needs and interests.

Reporting requirements and privacy concerns

OTA understands that although staff in RACFs are obligated to report any falls suffered by residents 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 RACFs increased after footage was aired of a carer appearing to suffocate a patient at a facility in South Australia. The carer 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 resolution/improvement would assist all concerned.

Recommendation 3: States and territories should enact mandatory reporting legislation that requires health professionals to report serious cases of elder abuse to authorities.

Recommendation 4: Video surveillance should be allowed in private rooms of RACFs with the permission of residents or their families and guardians.

Recommendation 5: 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. 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 Aged Care Funding Instrument (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 only be for 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 that oversees PCAs.

OTA was advised by an occupational therapist working in residential aged care that it is not uncommon for residents to suffer 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 managing palliative care clients within facilities (using syringe drivers to eliminate pain).

OTA believes that there needs to be greater supervision of residents. This would facilitate mobilisation, help eliminate pressure injuries and help 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, as they are best placed to prescribe equipment that meets the needs of each client. There have been situations where clients are given equipment simply because it is available in the storeroom.

Recommendation 6: 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 RACFs.

Recommendation 7: 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.

Recommendation 8: Provision of assistive equipment in RACFs should be overseen by a suitably trained occupational therapist who can assess the functional needs of residents.

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, particularly those with overseas qualifications, may not have sufficient knowledge of appropriate care techniques. Language barriers can also be an issue for overseas trained aged care workers, particularly if they are working with older people who are also from culturally and linguistically diverse (CALD) backgrounds.

Recent evidence suggests that due to staff shortages in aged care, current supervision and mentoring structures for new graduates 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.

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.

In a submission to the Senate Community Affairs References Committee's inquiry into the future of Australia's aged care sector workforce, OTA recommended that new graduates working in aged care be required to complete a structured work placement and be assessed by a supervisor, and that all aged care staff be required to complete refresher training.

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 properly and developing pressure sores as a result of a lack of movement.

OTA believes that aged care organisations 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.

Recommendation 9: New graduates working in aged care (in private, government and community practice) should be required to undergo a structured work placement and meet regularly with a supervisor who can assess their progress.

Recommendation 10: Staff in all aged care organisations should be funded to complete refresher training through online learning modules to ensure that their skills and experience remain up to date.

Recommendation 11: Direct care service providers should receive mandatory training in trauma informed care to enhance their ability to identify and respond to signs of elder 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.

Aged Care Quality Standards

OTA welcomes the introduction of a single set of Aged Care Quality Standards, which will replace the existing Accreditation Standards, Home Care Standards, National Aboriginal and Torres Strait Islander Flexible Aged Care Program Quality Framework Standards and Transition Care Standards. The new Standards are due to be implemented from 1 July 2018.

In many ways the existing Accreditation Standards for residential aged care are not sufficient to ensure quality of life for clients. Evidence-based care is often neglected in favour of convenience-based care that will meet the Standards and is cheaper/easier to provide.

Additionally, it is unclear what levels of knowledge staff in RACFs have of the intricacies of the Accreditation Standards. A key question to consider from an occupational therapy perspective is how therapists can meet the Standards when many are contracted into facilities on an as-needs basis. OTA acknowledges that not all aged care organisations have this sort of arrangement in place and do have their own therapy pools.

OTA believes that the robustness of accreditation review processes could be stronger in terms of the type of evidence that is accepted as compliance – particularly when demonstrating aspects related to individual staff responsibilities (eg. training), but also aspects of Standards 2 and 3 which relate directly to staffing and professional/clinical resourcing (eg. having an occupational therapist present in a RACF).

Rewarding good practice in residential care and sharing of this information by the Australian Aged Care Quality Agency (AACQA) would be beneficial. Sanctions should apply to facilities that do not comply with the Standards where possible serious risk of harm to consumers has been identified. The number of visits by the Quality Agency to facilities should be increased if there are complaints from a number of consumers about the same facility.

One occupational therapist advised OTA that while current sanctions are effective in terms of ensuring that the correct information has been provided when audits are conducted, they are less effective when it comes to ensuring that the Accreditation Standards are complied with. Additionally, auditing appears to be predominantly paper-based and as a consequence does not always reflect the reality of what occurs in the facility.

Recommendation 12: All staff who provide services in RACFs, including those who are contracted on an as-needs basis, should be required to have a baseline understanding of the new Aged Care Quality Standards which will take effect from 1 July 2018.

Recommendation 13: The robustness of accreditation review processes should be strengthened with respect 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 RACF sector.

Recommendation 14: Sanctions should apply to facilities that do not comply with the Quality Standards where possible serious risk of harm to consumers has been identified. The number of visits by the Australian Aged Care Quality Agency to facilities should be increased if there are complaints from a number of consumers about the same facility.

Assessment and monitoring process

In July 2017, OTA provided a submission to the Commonwealth Government's independent review of national aged care quality regulatory processes. We provided the following feedback in relation to the existing assessment and monitoring process:

> *The self-assessment and site audit should be retained. There also needs to be more emphasis on the perspectives of consumers and their representatives about the quality of care. This can be carried out by structured interviews but also informal discussions and focus groups.*
>
> *All four Accreditation Standards should remain with importance given to Standard 1 as the culture of the organisation affects all the other Standards.*
>
> *There needs to be more regular visits and more consumer input. The visits need to include staff interviews with a range of staff including allied health and visiting medical staff. There needs to be more emphasis on Standard 1, the management, the staffing, training and the culture of the organisation.*

One of our members also suggested that perhaps qualitative data should be gathered from clients and families if this is not already occurring. It is unlikely that staff would feel free to provide accurate information in some cases.

Recommendation 15: The self-assessment and site audit that form part of the current accreditation process should be maintained, however there should be a greater emphasis on the perspectives of consumers and their representatives with regards to quality of care. This could involve the gathering of qualitative data through structured interviews, informal discussions and focus groups.

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 turnover rate due to the pressure to see high volumes of clients to provide massages – usually using a hand massager. There is no real occupational therapy or physiotherapy work involved in this, and there is a great deal of pressure in the job to meet the quota per day – 60 plus people is not unusual, meaning therapists only really see a person for about three minutes.

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 absolutely false, as the entire job

involved managing the 4a/4b caseload using hand massagers. Residents often do not want a massage, however management strongly encourages staff to ask again and again if this is refused. If they continually refuse, the manager of the facility will usually talk to the resident and coerce them to change their mind.

The therapist noted that they never worked with any residents who refused, as they require consent before touching someone. There are many clients with dementia who are unable to provide meaningful consent due to their condition.

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

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

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

Other therapists have reported that they have been employed to deliver pain management programs so that RACFs can claim extra funding using the ACFI. Many are finding that their work roles do not allow for ‘occupational practice’ and at times they are being asked to work ‘out of scope’. Several occupational therapists had been trained by the facility in various modalities (such as transcutaneous electrical nerve simulation (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.

Occupational therapists are trained in assessment and management of pain as part of undergraduate and graduate entry curricula. The occupational therapy management of pain may use modalities common to other disciplines (such as relaxation, massage, time management, cognitive strategies and environmental adaptation). However, the unique contribution of occupational therapy to pain management is the occupational analysis and occupational adaptation approach – that is, person-centred evaluation of goals, tasks or occupations, and environments, with judicious use of a range of modalities to work towards occupational engagement. Additionally, pain in older people, particularly those with dementia, is complex to assess and treat and requires a multidisciplinary and multifaceted response. Simply using remediation strategies such as massage, TENS, ultrasound and acupuncture, is unlikely to successfully manage pain in an older person.

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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.

The ACFI is interpreted by the team of staff at each RACF, which is often led by a registered nurse. Multidisciplinary care teams are needed in all facilities to provide a range of treatment options for residents who may be suffering from a multitude of conditions. Ongoing dialogue between members of a client's care team is needed to better manage their condition and identify the most appropriate interventions.

Pain management is not the totality of occupational therapists' skills and experience in chronic disease management. Occupational therapy is not about simply managing pain; rather, occupational therapists are trained to assess changes in a person's functional capacity. Concerns have been raised that the ACFI is not aimed at improved or sustained quality of life, and residents are therefore missing out on 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 their care needs. This can reduce the likelihood of chronic pain and reduce hospital readmissions.

Recent review of the ACFI

The Review of the Aged Care Funding Instrument (ACFI) recommended that an expanded pain management program be introduced to residential aged care facilities, however we note that no decision has yet been made on the Review's proposed reforms. OTA is a strong proponent of the need for multidisciplinary allied health teams in residential aged care facilities. We believe that the changes to the ACFI proposed in the report will allow for more accurate assessments of a resident's needs, and the provision of a diverse range of interventions. Occupational therapists believe that participation in meaningful activities is fundamental to improving health and wellbeing, and we would welcome the introduction of a new therapy program focused on wellness and reablement.

Recommendation 16: Aged care organisations should be required to clearly specify the duties and responsibilities involved in any positions they advertise. Additionally, any false claims regarding the chance to gain experience in a particular area should be thoroughly investigated by the relevant authority.

Recommendation 17: Interventions and modalities funded under the ACFI should be expanded to take into account the broad scope of occupational therapy practice. Currently, residents requiring pain management are limited to a choice of transcutaneous electrical nerve stimulation (TENS) or massage, however there are other occupational therapy interventions that may be more beneficial (eg. reviewing seating/posture, or prescribing aids and equipment to increase mobility).

Recommendation 18: Aged care organisations 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, provide for greater awareness of the roles of different health professionals, and ultimately serve the interests of older Australians who would receive more holistic and coordinated supports and services.

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.

Two of the ten recommendations in the Senate Community Affairs References Committee's report from the inquiry into the adequacy of residential care arrangements for young people with disabilities were adopted from OTA's submission. One of our key recommendations was that the Commonwealth Government invest in upskilling and developing the professional carer workforce to ensure that RACF staff are able to provide the care and support that 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 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 be incentivised to meet additional standards through further funding opportunities and contribute to training and ongoing development of all professional and non-professional aged care staff.

2. Short Term: Assessment and management of 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 19: 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.

Summary of recommendations

- A coordinated approach to preventing and responding to elder abuse should be developed at a national level and led by an interagency taskforce.
- Primary Health Networks (PHNs) should work to educate the community about elder abuse in the health, disability and aged care sectors, and develop resources to assist staff in RACFs to identify common signs of abuse.

- States and territories should enact mandatory reporting legislation that requires health professionals to report serious cases of elder abuse to authorities.
- Video surveillance should be allowed in private rooms of RACFs with the permission of residents or their families and guardians.
- All aged care facilities should be required to publicly display a notice on how to report complaints.
- 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 RACFs.
- 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.
- Provision of assistive equipment in RACFs should be overseen by a suitably trained occupational therapist who can assess the functional needs of residents.
- New graduates working in aged care should be required to undergo a structured work placement and meet regularly with a supervisor who can assess their progress.

- Staff in all aged care organisations should be funded to complete refresher training through online learning modules to ensure that their skills and experience remain up to date.
- Direct care service providers should receive mandatory training in trauma informed care to enhance their ability to identify and respond to signs of elder abuse.
- All staff who provide services in RACFs, including those who are contracted on an as-needs basis, should be required to have a baseline understanding of the new Aged Care Quality Standards which will take effect from 1 July 2018.
- The robustness of accreditation review processes should be strengthened with regards to the type of evidence that is accepted as compliance.
- Sanctions should apply to facilities that do not comply with the Quality Standards where possible serious risk of harm to consumers has been identified, while the number of visits by the Australian Aged Care Quality Agency to facilities should be increased if there are multiple complaints about the same facility.
- The self-assessment and site audit that form part of the current accreditation process should be maintained, however there should be a greater emphasis on the perspectives of consumers and their representatives with regards to quality of care.
- Aged care organisations should be required to clearly specify the duties and responsibilities involved in any positions they advertise. Additionally, any false claims regarding the chance to gain experience in a particular area should be thoroughly investigated by the relevant authority.
- Interventions and modalities funded under the ACFI should be expanded to take into account the broad scope of occupational therapy practice.
- Aged care organisations should be required to invest in consumer-focused aged care teams that include allied health professionals such as occupational therapists.
- 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.

Appendix A: Types of interventions performed by occupational therapists working in residential aged care

Roles	**Some examples**
Early intervention in aged care: responding to people's needs as they begin to experience activity restrictions and participation	Restorative care Aged care assessment roles Occupational analysis of person and environment to enable clients to maintain their independence and maintain valued occupational roles
Enabling clients to regain or enhance their daily lives	Short term rehabilitation programs Splinting to enhance continued upper limb function and reduce pain Falls prevention programs Pain management Exercise classes Seating and posture prescription Pressure care

Assessing and modifying clients' home and community environments to improve their safety and independence	Community mobility evaluation, including driver assessment and rehabilitation Falls prevention
Recommending and educating clients and carers in the use of adaptive equipment to assist function	Powered scooter prescription Eating equipment/adaptive devices Smart assistive technology (eg. alerts for dementia clients) Hoist prescription and education to carers and staff
Behaviour support	Recommending equipment, increasing independence, modifying the environment to assist in behaviour management in residential care Running "living with memory loss" programs Developing personalised activity programs to maintain engagement in occupations
Psychosocial evaluation and use of structured activity to maintain and enhance occupational roles	Occupational role evaluation and daily living planning Organising appropriate activities to accommodate wandering in residential care
Systemic roles	Embedding reablement and wellness approaches in aged care teams Advising local government on access and age-friendly environments Access evaluations for residential aged care by occupational therapists with access audit credentials