Royal Commission
into Aged Care Quality and Safety

Statement of Anna Urwin

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Date:	June 2019 2019

1. This statement made by me accurately sets out the evidence that I am prepared to give to the Royal Commission into Aged Care Quality and Safety. This statement is true and correct to the best of my knowledge and belief.

2. The views I express in this statement are my own based on my education, training and experience.

Background

3. I am a qualified physiotherapist, currently working in a coastal town in Western Australia.

4. I commenced a Bachelors in Physiotherapy in 2015, and completed it in October 2018. As part of that degree, I completed a clinical placement at a residential aged care facility in Perth in 2016. The majority of students are required to do an aged care placement, as aged care is such a big part of modern physiotherapy practice.

5. After completing that placement, I was offered a position as a therapy assistant while I completed my degree, which I accepted. I worked there for about a year and a half spread out over my degree before I graduated and got my current job.

6. I am now working in a clinic which offers contracted physiotherapy services to a number of places including the local private hospital, a large medical centre, water based group therapies and (until recently) a local residential aged care facility. We also run a private clinic. The clinic has recently ceased providing services to the local aged care facility, but I was involved in that work for about 2.5 months.

7. I am really pleased and excited to be working in this role, because of the variety of work I get to perform.

Person-centred care

8. Person-centred care to me means that each person gets individualised treatment, as opposed to simply applying a standardised approach. It is important to make an assessment of each patient's goals and functions and

abilities. Once we identify a problem in an area of function, it's about improving that area by applying evidence based treatment in order to improve their overall quality of life.

Current state of person-centred care in aged care

9. The potential positive impact of physiotherapy should not be understated. We have an ageing population, and people are living longer with a larger variety of conditions. The role of physio is to assist people to live their best quality of life through evidence based treatment. We have the ability to work with patients to increase their physical function and enable them to be more active participants in their own environment and community.

10. At the moment that focus just isn't there. The majority of work we do is almost pointless.

11. In aged care, we are funded through the ACFI model to provide physio to residents who are on the 'pain clinic list'. We are specifically funded, under ACFI , to provide treatment to residents who are divided into two levels of care. The people under 4A require 20 minutes per week of massage or TENS (electrical stimulation) and the people under 4B require 20 minutes 4 times per week. One of these two therapies are applied regardless of the specific cause of each resident's pain or their goals and abilities.

12. Neither therapies are evidence based, and should not be performed as a base treatment for pain relief. Yet we are brought in to perform 20 minutes of massage, 4 times per week for most residents so that the facility can tick that box and receive the funding.

13. I am frustrated by the pointlessness of it. We have so many patients to get through, we are rushing to provide all of this passive therapy which is likely to do nothing to address that patient's pain. There are of course some patients who have the sort of pain that massage is good for, and in some cases it may be helpful to alleviate very short term pain. (For example massage can provide soft tissue relief.) However for people with chronic pain - which includes the majority of the residents - what we are doing will (generally speaking) do nothing.

14. Ideally we would make individual assessments and tailor specific treatments and activities for residents on the pain list, with a view to getting them off the pain list, but there is no funding under the current model for it. If a patient wanted that kind of care, they would have to organise it and pay for it themselves.

15. Management of the facility push and push to get more people on the pain list, but there is not the same motivation to remove people from the list. I think that they are motivated by funding; facilities receive additional funding for residents who are assessed as having issues with pain. It concerns me that such an approach is necessary; where are the deficiencies in funding in other areas that cause facilities to try and increase their funding through the pain list?

16. The difference an individualised, evidence based approach could make is significant. Sometimes people are transferred to aged care homes from rehabilitation centres or hospitals because they are no longer eligible - I observe this in my current role at the hospital. These people might not actually be able to perform a basic sit to stand motion in order to get out of their chair, or lower themselves onto a toilet, but they have the potential to perform these functions after physiotherapy, if only we were funded to have sessions with them. These people are capable of having a better quality of life and we are not funded to enable them to have it. They will never improve without basic functional input.

17. This has a flow on effect to carers. Whereas a person might otherwise be able to get themselves out of bed or out of their chair, they now need a carer to assist them. They might be a two person assist, or they might require machinery to get them up. They are not given the opportunity to regain that sense of dignity and autonomy that comes from being able to take yourself to the toilet, something they have been doing their whole lives.

18. The current approach lacks basic decency and what frustrates me is that we have the ability to assist; we have the skills; we have the training; we are willing and able. These people are paying so much money just to sit in an aged care home while their functionality deteriorates and it does not have to be that way.

19. I think it all comes back to funding, and specifically the ACFI funding model. Facilities almost get a reward if people are in pain. I have never seen someone come off the pain list, unless they pass away or they become so incapacitated that it is undignified to be massaging them. I struggle with it morally.

20. What is additionally frustrating is that patients are reasonably well assessed when they first enter residential facilities in order to ascertain the constraints of their mobility function. Then we do nothing about improving that position. It appears to me that people are assessed for the purpose of obtaining ACFI funding, not for the purpose of treating them.

21. The effect of being compelled to provide ineffective care extends beyond just the inadequate clinical outcomes for patients. It is also affecting who is prepared to work in aged care. In our final year of University, all of the physio students were looking for graduate jobs, and nobody wanted to go into aged care. We spend four years learning all of these amazing skills, and if you go into aged care you know that you will never get to use them.

22. Motivating high quality professionals into the area of aged care is a real problem, particularly considering the ageing population. I see it crossing into locums now. We no longer service the local aged care facility, but I have spoken to the current locum who is dismayed by the work too. She trained overseas and has relocated to Australia and is in total disbelief about the state of the system. It is so unappealing for both Australian students and people from overseas to work in.

23. I don't think that money is a factor for physiotherapists. We get paid a really good amount for the subpar service we are permitted to provide. I feel uncomfortable knowing that carers who are having to deal with toileting and personal care for so many residents are being paid half of what I am.

Choice and control

24. In my experience, residents are not given a lot of choice in the care that they receive, and the amount of choice they get declines if their cognitive capacity declines. A facility I worked in previously had 2 wards. People in one ward were reasonably high functioning; you could have a conversation with them. You could talk to them about the treatment you were going to provide, and they were capable of saying yes or no. If they said no then that was the end of discussion. In my most recent aged care role, even this element of choice was changing as management continued to push for box ticking - we were required to try the resident multiple times if they refused treatment in the first instance. It seemed quite demeaning for the cognitively intact residents to be asked the same question multiple times when a clear answer had already been given.

25. On the dementia side, which is where I performed the bulk of my work, many were unable to communicate verbally, although some could communicate with movement or physical reactions. Sometimes I could see that people who were being massaged didn't enjoy being touched, but they were pushed to participate in it, so administrative requirements could be met. Sometimes if it was clear to me that someone did not want to participate, I just ticked them off. That way management got their tick and the patient did not have to be touched when they didn't want to be.

26. I struggle to see how some of the dementia patients were assessed as having pain at all, some were entirely unresponsive. There is no element of choice in their current treatments.

Changes to current system

27. I think that in order to reform the care delivered in a residential aged care setting, you need to reform the funding model. There is undue focus on ticking ACFI boxes and not enough focus on delivering the type of care that each individual needs.

28. I think that a lot of things in the aged care industry come down to money. The focus should be on care. It worries me that physio has to be capitalised on in the way that it is for facilities to get the money they need.

Conclusion

29. Essentially, our population is going to continue to age and numbers of people entering residential aged care will only increase. The access we currently have to the most recent evidence based practice on maximising physical function and alleviating pain gives us absolutely no excuse to continue practicing as we are.

We must approach this with the perspective that even people nearing the end of life have benefits to gain from improving in function.

30. The system at the current time does not reflect person centred care from a physiotherapy perspective and there must be an opportunity for greater autonomy to provide individualised treatments in order to help residents of aged care facilities to live with the best quality of life possible.

Signed: _____

Date: 12.06.19

Witness: _____ SALLY MCKENZIE

Date: 12.6.19