**Royal Commission**
**into Aged Care Quality and Safety**

# QUESTIONS FOR DR STEPHANIE WARD

**Please outline your professional qualifications and background, in particular your practice as a consultant geriatrician.**

I am preparing this statement in my private capacity as a consultant geriatrician.

With **respect to my qualifications**, I have a Bachelor of Medicine from The University of Newcastle, awarded in the year 2000, a Fellowship of the Royal Australasian College of Physicians in Geriatric Medicine, conferred in the year 2008, and a Master of Public Health from Harvard University, awarded in the year 2010. I commenced a PhD with Monash University in 2017, with confirmation of candidature awarded 2018. I am now undertaking this PhD part time and it is presently on hold.

With **respect to my practice as a consultant geriatrician**, I have worked continuously as a consultant geriatrician since February 2009, with two periods of one year's leave. I have worked predominantly in a part-time clinical capacity, balancing this with academic interests. I presently have an appointment at a public hospital in Sydney and an appointment with a university.

My clinical career as a consultant geriatrician has taken place in three separate public health services across both Victoria and New South Wales. As a consultant I have worked in acute geriatric inpatient care, subacute inpatient care (geriatric evaluation and management- unit, including for persons with dementia, and rehabilitation), in an inpatient and community based transitional care programme, with an aged care assessment team conducting home assessments in the community, in a multidisciplinary falls clinic and in two multidisciplinary memory clinics, and in acute and subacute geriatric outreach to residential aged care facilities.

My present clinical work includes leading the geriatric outreach service to local residential aged care facilities (RACFs) for my hospital, and working in a cognitive disorders clinic, which is an outpatient clinic for community based older adults with dementia and other cognitive disorders. I thus have experience in working in multi-disciplinary teams for both inpatient and outpatient care. I have conducted approximately 400 medical reviews of older persons living in RACF in the past 12 months in 18 separate facilities.

**Please address the following based on your professional experience.**

**Unless otherwise specified, please consider both residential aged care and aged care services provided to people living in the community.**

- **Common allied health care needs of people receiving aged care services (identifying those needs that are likely to be frequent and ongoing, and those which are likely to be infrequent or episodic)**

  Older adults who receive aged care services at home or in RACF often have complex healthcare needs, are frail and have multiple co-morbidities that impact upon function, quality of life, and mental and cognitive health[1].

  In RACF most residents need some assistance or supervision for mobility, or are no longer mobile at all[1]. Many have experienced, or are at high risk, of falls. Weight loss, poor oral intake and difficulties with swallowing are common concerns for both staff and family members. Other common issues include polypharmacy, with high prescription rates antidepressants, antipsychotics or sedatives. The significant increase in use of such

medications after admission to RACF in Australia, as demonstrated in a recent analysis of administrative datasets[2], points to a psychological impact when transitioning into RACF for many residents. The high prevalence of anxiety[3] and depression[4] symptoms in residents in RACF has also been well documented.

Recipients of aged care services at home may have slightly different needs, often with a higher baseline level of mobility, however risk of falls, issues of weight loss, polypharmacy and additional complex social situations are prevalent. The challenges in supporting and re-enablement of persons living with dementia in the community have in particular been well highlighted[5].

Thus, the needs for allied health professionals for persons receiving aged care services, both in the community and in RACF, from my experience include:

i) **Physiotherapy** – in RACF for **baseline assessment** of mobility needs and goals, development and oversight of a programme to optimise mobility and balance, and prevent deconditioning. There is also a **need for reassessment** after a change in function and mobility – including after a fall, after an injury, or following an acute illness.

   An **ongoing role for physiotherapists** in leading exercise groups – both aerobic and resistance training **-** is substantiated by randomised controlled trials that demonstrate benefits of such programmes in RACFs on outcomes such as gait speed, strength and balance[6-8].

   For recipients of **aged care services at home**– there may be a need for physiotherapy, depending upon the client's mobility, and risk of falls.

ii) **Psychology** – for the assessment and development of management plans for highly prevalent anxiety and depression symptoms in RACF, and for support in the significant grief that many residents experience with their transition into RACF. Psychological interventions may be less required in the setting of advanced neurodegenerative change and are more likely to be **required on an episodic basis**. They may not be suitable for residents with more advanced dementia.

   For recipients of **aged care services at home**, access to psychology can be more easily accessed through a GP Mental Healthcare Plan.

iii) **Social Work** – in RACF can support residents and/or their families with the initial transition to residential aged care, and in support for overseeing requirements for permanent entry into residential care, as many residents transition from respite to permanent care. These periods can often, and understandably, be overwhelming for residents and their families. These needs are likely to be **episodic**.

   For recipients of **aged care services at home**, access to social work may be required on an **episodic basis** to deal with particularly complex social situations. These may include future accommodation planning, when there are issues of risk and impaired decision making capacity, or when an older adult is socially isolated, and in the setting of elder abuse.

iv) **Diversional therapy** – in RACF, is particularly important in overseeing and developing **ongoing meaningful** activity programmes that engage and stimulate residents, and avoid boredom. The importance of this cannot be under-estimated. Boredom, lack of purpose and joy can exacerbate feelings of depression, isolation and may manifest also as the behavioural and psychological symptoms of dementia[9].

v) **Occupational Therapy** – Occupational Therapists are trained in the assessment of capacity to undertake activities of daily living. In RACF, ideally, **an occupational therapist would undertake this assessment at baseline**, to work with a resident to identify goals and opportunities to maximise the independence of the resident, noting that this may require appropriate equipment and aids. A re-assessment may be required if a resident's goals or health status changes significantly, for example and especially if a resident is considering returning home.

Occupational therapy plays an important role for persons receiving **aged care services at home**. This includes in the identification of risks in the home, advice on modification of the home environment, and assessment of function of an older person in their own home environment.

The role of occupational therapy in the re-enablement and support of persons residing in the community with dementia should also be highlighted[10].

vi) **Speech Pathology** – when concerns are identified with respect to swallowing and/or frequent chest infections, and when communication and speech difficulties exist, including after stroke. Such input is likely to be **episodic**.

These needs also exist for community-dwelling older adults, and in particular may be required by persons with certain neurodegenerative diseases – such as fronto-temporal dementia- which impact upon speech. For a sub-set of individuals these needs may be ongoing[10].

vii) **Pharmacy** – to assist in addressing polypharmacy, and assist general practitioners in optimising medication choices, both in RACF and in the community. The benefits of pharmacy-led reviews conducted in both RACF and community settings have been well established by studies[11].

viii) **Dietician** – to review residents of RACF in the setting of weight loss or to provide guidance in the setting of certain healthcare conditions eg diabetes.

Older adults living in the community – alone- are often at high risk of weight loss (especially in the setting of dementia) and there is frequently a need for review by a dietician. These needs are likely to be **episodic**.

- **The role of allied health in maintaining or restoring the physical wellbeing and functionality of people receiving aged care services, including the role of early intervention allied health care**

Allied health staff play a critical role for the maintenance and restoration of the physical and functionality of older adults who require aged care services. The importance of the role of allied health in care of older adults is clearly well-recognised by healthcare providers. It is not unusual for acute aged care teams, geriatric evaluation and management units, inpatient rehabilitation teams and even outpatient speciality clinics (such as falls clinics, memory clinics, movement disorders clinics, chronic pain clinics) to be staffed by a multi-disciplinary team that features expertise from a breadth of allied health professionals[12]. Health services provide access to allied staff in these settings because it is beneficial, and evidence shows relevant outcomes in hospital can be improved with increasing access to allied health staff (e.g. on length of stay)[13].

Many of these needs persist when older adults transition from hospital to the community or to RACF, or enter into receipt of aged care services in either setting without a prior hospitalisation.

Early intervention from allied health is recognised as important in the hospital setting, and is no less important in the RACF or community setting. Early intervention includes assessment, goal setting with the aged care recipient and formulation of a management plan.

- **Access to different disciplines of allied health services by people receiving aged care services, and any barriers to access (identifying any challenges that may be of particular relevance to people receiving residential or home care services)**

In the RACF setting, some facilities – including facilities – have members of allied health professionals on staff (ie employed by the facility). This is commonly physiotherapy and social work, allied health assistants, and on occasions occupational therapy. Other facilities refer to private providers on a needs basis of the residents.

Barriers to access in RACF include the timely identification of a need of an allied health professional, and the cost to the resident of a referral. In my clinical experience I have found that requests for referrals to speech pathology and dieticians are usually met. However, sourcing additional physiotherapy intervention and support for residents with particular needs can be difficult to meet above what is usually provided in RACF.

For community-based recipients of aged care services, again the timely identification of the needs of older adults for allied health can be a barrier. Aged Care Assessment Teams previously were able to play a very useful role in assessing the varied needs of older adults requiring aged care services, and provided a useful “checkpoint” to initiate and oversee appropriate referrals, sometimes obviating a need for aged care services or entry into residential care. Access to many such services may be through My Aged Care, which can prove difficult for some older adults or their family members to navigate. Access via interaction with hospital outpatient and outreach services can make this easy for older adults who are connected in.

- **The role of general practitioners and geriatricians in identifying allied health needs and referring older people to allied health services**

Both general practitioners and geriatricians play an important role in identifying the need for access to allied health staff. General practitioners are the first point of contact for both community-based recipients of aged care services, and those residing in RACF. General practitioners have the benefit of caring over a period of time and reviewing periodically to regularly to identify needs as they emerge.

Geriatricians are medical specialists that are trained in the holistic assessment of any older person. The comprehensive geriatric assessment that is typically undertaken by a geriatrician reveals all medical, functional, cognitive, psychological and social issues relevant for their patient at that time. This underpins the development of a patient-centred management plan. This is an excellent opportunity to identify the need for any expertise from allied health professionals.

In my practise as a consultant geriatrician, I frequently identify the need for input from an allied health professional when I complete a comprehensive geriatric assessment in either an outpatient setting for a community-based client, or for a resident in an RACF.

It is essential to ensure clear communication between a patient's regular general practitioner, and the geriatrician, in developing such a management plan, as well as with the recipient of services and their family members.

Geriatricians as medical specialists are not in a position to subsume the role of the general practitioner. Best outcomes ensue when the two medical practitioners work together.

- **The role that allied health practitioners can play in assessments, development of care plans and care coordination for people receiving aged care services**

  Allied health staff are experts who are trained to assess care needs of adults who require aged care services. Many Aged Care Assessment Teams previously operated as interdisciplinary teams with assessors bringing a range of allied health backgrounds to their roles as assessors, and as outlined above this process provided a useful checkpoint.

  In the RACF setting, an allied health specialist will have had the requisite training, and have the requisite skill, to undertake a thorough assessment including of mobility (physiotherapy) and capacity to undertake activities of daily living (occupational therapy).

  The assessment and development of care plans are optimised in the setting of a team approach (see below).

- **The benefits of including allied health practitioners in multi-disciplinary health care teams, in particular teams embedded in residential aged care facilities, and the extent to which multi-disciplinary health care teams currently include an allied health presence**

  The benefits of a multidisciplinary, as well as interdisciplinary approach to the provision of excellent health care for older adults have been well established[12]. These teams form a standard approach for both inpatient and outpatient care of older adults through hospital services.

  The benefits can extend to an RACF setting. In a small number of RACF I visit I am able to interact with a multidisciplinary team (MDT) and my clinical experience is that this is advantageous for residents and their families. As a consultant geriatrician, being able to discuss a resident onsite with a facility's physiotherapist, social worker or occupational therapist very much aids my assessment of residents in developing a more comprehensive understanding of mobility and functional needs, and in developing a management plan.

  This accords with my experience of working in a hospital where geriatricians usually work as part of an MDT, and is the standard of care in the hospital practise of geriatric medicine. The other standard practise in a hospital setting is the "case conference", where the comprehensive status and goals of a patient are discussed, with expertise from various

medical, nursing and allied health professionals leveraged to develop the best plan in accordance with patient and family preferences[12].

There is a significant opportunity to model a similar approach in an RACF. This may not be achieved by relying on separate private providers.

There are additional benefits to an embedded team, including shared learning and up-skilling, culture change and accountability[12,14].

- **Changes that you think could be made to improve the delivery of allied health care to people receiving aged care services**

It is my opinion, formed by both my clinical practise and reading of the relevant literature, that there is considerable scope for increasing the access to allied health staff for recipients of aged care services.

There is a considerable evidence base that underpins the roles of individual allied health staff in addressing a multitude of healthcare needs of complex older adults. These range from benefits of increased support for mobility and exercise, such as rigorous randomised controlled trials demonstrating the benefits of physiotherapy led exercise programmes with beneficial effects on mobility and quality of life[6-8], to the role of occupational therapy in supporting re-enablement of older adults, including those living with cognitive impairment[5].

The evidence base also underpins the interactions between different specialities as forming part of a multidisciplinary, or even interdisciplinary team. A case conference can be central to this[12].

My thoughts on opportunities to improve allied health access are as follows:

* I support embedding multidisciplinary teams within facilities, or across facilities within an organisation. The word "team" implies a group of individuals who work together towards a combined goal.

* Opportunities for embedded allied staff to train and upskill other staff within a facility should be capitalised upon. This could include training of personal care attendants, and allied health assistants, to support a restorative approach to resident care.

* Opportunities for development and maintenance of programmes for groups of older adults within either RACF or in the community should be explored (e.g. exercise groups).

* Increased involvement of geriatricians in participating in a facility-based MDT would be beneficial. Geriatricians are specialists trained in the holistic assessment of older adults and experienced in the leadership of a MDT and bring an overarching approach to a resident's overall management plan. It is not uncommon for residents in RACF to have previously had the involvement of multiple medical specialists in their medical care, but this often ceases with entry as attending private clinics or appointments becomes more logistically challenging. The role thus of a geriatrician is even more critical to now oversee the management of complex health issues.

* Long term care institutes in the United States of America often have clinical stewardship by a geriatrician. In Australia, access to geriatricians may occur by referral to private

provider. Some hospitals may be able to support RACF with some access to geriatrician time. Overall, access can be variable.

However, an explicit relationship with a community-based geriatrician/s and a facility, with accountability within a facility-embedded MDT, could be highly advantageous.

* Case conference of residents of RACF by an MDT embedded within a RACF would be very useful. This may occur after admission, periodically (e.g. 6 monthly), and after a change in healthcare status.

**References**


1. Eagar K, Westera A, Kobel C. Australian residential aged care is understaffed. Med J Aust 2020;212(11):507-8.e1.
2. Harrison SL, Sluggett JK, Lang C, Whitehead C, Crotty M, Corlis M, et al. The dispensing of psychotropic medicines to older people before and after they enter residential aged care. Med J Aust 2020;212(7):309-13.
3. Creighton AS, Davison TE, Kissane DW. The prevalence, reporting, and treatment of anxiety among older adults in nursing homes and other residential aged care facilities. J Affect Disord 2018;227:416-23.
4. McSweeney K, O'Connor DW. Depression among newly admitted Australian nursing home residents. Int Psychogeriatr 2008;20(4):724-37.
5. Bayer A. Next steps after diagnosing dementia: interventions to help patients and families. Pract Neurol 2020.
6. Chou CH, Hwang CL, Wu YT. Effect of exercise on physical function, daily living activities, and quality of life in the frail older adults: a meta-analysis. Arch Phys Med Rehabil 2012;93(2):237-44.
7. Valenzuela T. Efficacy of progressive resistance training interventions in older adults in nursing homes: a systematic review. J Am Med Dir Assoc 2012;13(5):418-28.
8. Scrivener K, Alava Bravo K, Greely B, Heidema M, Violi A, Young N. An ongoing physiotherapist-led exercise program in residential aged care: Description of participant satisfaction and outcomes. Australas J Ageing 2020.
9. Kales HC, Gitlin LN, Lyketsos CG. Assessment and management of behavioral and psychological symptoms of dementia. Bmj 2015;350:h369.
10. Committee GA. Clinical Practice Guidlines and Principles of Care for People with Dementia. Sydney: Guideline Adaption Committee; 2016.
11. Chen EYH, Wang KN, Sluggett JK, Ilomäki J, Hilmer SN, Corlis M, et al. Process, impact and outcomes of medication review in Australian residential aged care facilities: A systematic review. Australas J Ageing 2019;38 Suppl 2:9-25.
12. Ward SA, Workman B. Multidisciplinary Teamwork. In: Caplan G, editor. Geriatric Medicne An Introduction. Melbourne: IP Communications; 2014.
13. Mills E, Hume V, Stiller K. Increased allied health services to general and acute medical units decreases length of stay: comparison with a historical cohort. Aust Health Rev 2018;42(3):327-33.
14. Ellis G, Sevdalis N. Understanding and improving multidisciplinary team working in geriatric medicine. Age Ageing 2019;48(4):498-505.