Australian Physiotherapy Association
Submission

Supplementary evidence to Senate Standing Committee on Community Affairs (Legislation Committee) Inquiry into Aged Care Amendment (Implementing Care Reform) Bill 2022 [Provisions]

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25 August 2022

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AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Questions

How does multidisciplinary assessment work in practice?

There are different ways multidisciplinary assessment works depending on how a facility is staffed. Usual practice is for a single professional to have a screening/ broad assessment which identifies client goals and participation barriers/clinical issues. This healthcare professional can facilitate onward referrals to other allied health practitioners, nurses and GPs, who can add any additional referrals they feel are required.

The key is for these assessments to occur in a timely manner with a shared client record which allows for viewing of other assessments. If there are overlapping issues and interventions these need to be coordinated between professionals a multidisciplinary team meeting is used to discuss the clients goals where for the sake of efficiency usually multiple clients would be discussed in the one meeting.

Allied health professionals work together with the client and also communicate with personal care workers, leisure and lifestyle and clients families to develop care plans, refer to exercise and wellness programs to improve a resident's quality of life.

In gerontology, specialised clinics that exist in hospitals usually may have professionals located within the clinic who assess the client in one assessment at which the client may see multiple professionals at once or sequentially on one day. The team would then meet to discuss the case and make recommendations/ referrals.

Is it too late for allied health given AN-ACC comes in on 1 Oct and there is a reduction in hours already?

Once you lose qualified staff with the passion, dedication and knowledge to work in residential aged care it will be hard to get them back. The reality is that allied health care, such as physiotherapy, is needed and wanted by older people, and many facilities understand its critical role in preventing, diagnosing, treating and managing chronic conditions. There will be an ongoing demand and need. What will be lacking is mandated requirement about the types and levels of care provided. It is not too late to work with the Government to achieve a mechanism to ensure allied health assessment, care planning and provision is accessed to older people .

How would transparency result in increased access to allied health care?

Monitoring and public accountability for the assessment and service delivery by allied health individual profession/service is critical to understanding the type and levels of service provided to older people. This data can be leverages to identify and address shortfalls – and give consumers full visibility of what individual facilities are providing to their residents.

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Case studies

Case study 1: diagnostic ability of physiotherapists and their support to nurses and carers **(Adelaide, South Australia)**	Mrs A was in severe pain and experiencing serious bladder issues. She was so distressed and uncomfortable that she was expressing suicidal idealisation and refusing food. There had been previous incorrect diagnoses and Mrs A felt she was not listened to. Her physiotherapist diagnosed cellulitis, assessed a possible bladder obstruction and recommended an ultrasound investigation. The physiotherapist called the woman's family and a GP to prescribe antibiotics. The physiotherapist encouraged and assisted Mrs A to be mobile to improve her circulation, prescribed support bandages to control swelling and updated her care plan to include carer supervision of transfers to reduce falls risks. The physiotherapist bandaged her legs so she could walk. The nurse welcomed this support. She was upset because she had tried to help the resident for most of the day but was feeling unsupported. The client felt calmer after son's visit and was persuaded to eat by the physiotherapist.
Case study 2 **Physiotherapists training other staff** **(Taigum, QLD)**	Mrs K has Parkinson's disease and was experiencing particular trouble with walking. Shortened steps and other walking disturbances are symptoms of Parkinson's Disease. It brought on significant anxiety when he needed to be physically assisted to the toilet. He was rushed and this worsened his symptoms. His physiotherapist practiced cueing strategies (visual and auditory) and provided education and research articles on Parkinson's Disease to Mr D , his family and to the nursing and care staff, with good effect and all understanding of the best way to care for and support Mrs K. After implementing this education and physiotherapy interventions, Mrs K experienced reduced frequency of walking disturbances and reduced anxiety with completing care and felt an increase in quality of daily life. Currently working on next SMART goal of being able to mobilise to dining room with 1 person supervising or assisting – removing her current need for a wheelchair. Mrs K is very excited about her progress and keen to continue. Mrs K and family provided good feedback to Residence Management, which is a significant change as Mrs K is normally one to lodge formal complaints frequently.
Case study 3 **Multidisciplinary care** **(Kedron, QLD)**	Mrs X, 89, was admitted to a residential aged care facility following a long-stay hospital admission for a serious illness that led to a rapid decline in her function and cognition. Prior to the recent hospitalisation, Mrs X had been living independently in her own home, performing most daily living tasks independently, and walking with a 4 wheeled walker up to 350 metres. When she left hospital, she was in a full sling

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	hoist, with two people needed for transfers, and she required assistance with all activities of daily living. The allied health team at the residential aged care facility was approached by Mrs X' daughter, seeking private physiotherapy services to assist her mother in improving her mobility, independence, and quality of life. Upon initial physiotherapy assessment, Mrs X had significant weakness in her leg and trunk muscles. She was unable to roll or move herself independently on the bed, and was bedbound or transferred to and from a regency chair using a full sling hoist. Her ankles were kept in a flexed (downward pointing) position. She was was also assessed to have severe pain and stiffness with contractures in her left arm and unable to open her left hand. The daughter discussed her long term goal with the physiotherapist, which was for this patient to return to walking. Following the assessment, the physiotherapist recommended an occupational therapy review to review her seating, pressure relief options to reduce the risk of pressure sores from immobility splinting options for her feet, and to review her painful left hand contracture. Mrs K began twice weekly physiotherapy treatments, which continued for 5 months. Working with her physiotherapy and occupational therapy resulted in her being able to walk unaided for 70 metres, open her hand to hold small objects, was able to sit without support, and was able to independently stand without hands-on assistance. A multidisciplinary approach was adopted to ensure best patient care. Both physiotherapist and occupational therapist liaised with the care staff and allied health team at the facility, making recommendations for carers with correct splint positions, contracture skin breakdown prevention, reviewing the patient's transfers with hoists and mobility aids, and recommending to the facility allied health team that Patient X be regularly provided with stretching and pain management for her hand contracture.