Occupational Therapy & Dementia Care in Long-Term Care Homes

A proposal for a non-pharmacological solution to support patient-focused care and management of responsive behaviours

February 28, 2017

Ontario Society of Occupational Therapists

- **Occupational therapy** is a person-centered health profession concerned with promoting health and well-being through enabling people to participate in the activities of everyday life
- Occupations are those activities that one needs and wants to do. Engagement in meaningful activity contributes to a sense of purpose, self achievement, self worth, confidence & independence – important factors for health & well-being
- Occupational therapists work with people across the lifespan who experience barriers to managing day to day occupations – self care, care for others, managing their household and/or their job/school, engaging in relationships, contributing to their community, etc.
- OTs work with their clients to find solutions to remove or minimize barriers, enabling optimal function. OTs consider the physical, cognitive, affective and spiritual dimensions of the client's occupational goals and performance, and have a unique focus on the social, cultural and physical aspects of the environment in terms of how it can either enhance or interfere with occupational engagement

Ontario Society of Occupational Therapists

The Challenge of Dementia….

- Cognitive deficits – memory, sequencing, problem solving, orientation (time,place)
- Decreased functional ability & independence
- Increased risk of harm – falls, wandering
- Behavioural & psychological symptoms – psychosis, aggression, agitation, depression, apathy, mania
- Caregiver stress & burnout
- 90% of LTCH residents have some level of cognitive impairment – 1 in 3 are severely impaired
- 46% exhibit aggressive responsive behaviours (OLTCA)

Ontario Society of Occupational Therapists

Impacts of Behavioural Symptoms & Responsive Behaviours

- Resident needs may be unidentified – pain/discomfort, hunger, boredom, freedom of movement
- Secondary consequences of behaviours – e.g. falls, poor wound healing, ER admissions
- Risk of harm to resident and potentially other residents
- Increased care & cost of care
- Increased staff stress & longer term implications
- Attention to use of anti-psychotic medication, restraints

Ontario Society of Occupational Therapists

Problem behaviours are a consequence of interacting factors

- Patient based – unmet needs, discomfort/pain, loneliness, boredom, medical condition (often unidentified)
- Caregiver based – stress, communication style
- Environment based – clutter, level of stimulation, accessibility, hazards, restrictions to function

They are manifest in depression, agitation, impatience, wandering, aggression, violence

Ontario Society of Occupational Therapists

The occupational therapy solution

- Occupational therapy is an obvious resource to address the person, occupation, environment context & factors that contribute to responsive behaviours
- OT aligns seamlessly with the PIECES Framework & behavioural theories of unmet needs & environmental press
- OT interventions are based on functional analysis which is described by international guidelines as a first alternative to drug therapy for challenging behaviours

Ontario Society of Occupational Therapists

Bringing OT into Ontario LTC Homes

- Goals:
  - Resident-focused interventions to **meet resident needs**
  - Proactive approach to **prevent problem behaviours**
  - **Prevent consequences of responsive behaviours -** falls, wandering, pressure sores, disruption of other residents, increased demands on staff time
  - **Build capacity within LTC Homes** to address responsive behaviours

Ontario Society of Occupational Therapists

Projected Outcomes

- Improved resident experience & quality of life…putting patients first
- Improved quality of care with broader range of interventions to address needs of residents with dementia
- Reduced frequency of responsive behaviours & resident on resident violence
- More effectively supported mobile BSO Teams impact – promote translation of team recommendations to action, provide insight to Team re resident behavioural profile
- Enriched care team support – consultation/education, reduction in disruptive behavior
- Enhanced behavioural/functional resource for all residents of LTC Home – ADL, environmental adaptation, seating & mobility, wound care, cognitive assessment/training,
- Increased capacity of nursing & other staff to address issues affecting responsive behaviours
- Positive impact on indicators including frequency of behaviours, residents on resident violence, falls, restraint use, reduction in admissions to ER

Ontario Society of Occupational Therapists

How do OTs work with residents with cognitive decline?

- Assessment/screening – identifying deficits and strengths in cognitive function
- Assess how these impact ability to function in day to day life in LTCH – ADL, mobility, social skills, leisure pursuits, IADLs
- Identify interventions/strategies to minimize the functional impact of their dementia, for example:
  - Cueing
  - Modification of the environment – e.g. room set up, signage
  - Communication strategies – e.g. alternatives to verbal
  - Realistic goals for increased independence & restorative approaches for ADL, mobility, etc.

GOAL IS TO MEET UNMET NEEDS THAT CONTRIBUTE/TRIGGER RESPONSIVE BEHAVIOURS

Ontario Society of Occupational Therapists

How do OTs work with residents with cognitive decline?

- Assessment/screening is an individualized professional intervention – 1:1 OT:resident
- Interventions address unmet needs & are therefore necessarily individualized
- Interventions largely delivered on 1:1 basis to enable focus on individual strengths and needs, although some functional skills may lend to group interventions when more than 1 resident has similar needs – e.g. feeding groups, mobility groups
- Aspects of OT intervention may be assigned by registered OT to OT Assistant – enables efficiency, maximization of OT resource, repetition/practice
- Standards for supervision of support personnel require that OTs assign only components of treatment for which they know the OTA is competent and that they provide for a means for direct supervision

Ontario Society of Occupational Therapists

Occupational Therapy in Long-Term Care

What Occupational Therapists can offer the residents and staff in LTC Homes

OTs enhance quality of life through enabling participation in meaningful, everyday activities!

ADL Assessments & Restorative Care

- OTs assess residents' performance of their everyday tasks such as eating, grooming, dressing, bathing, and toileting. OTs can then develop individualized, resident-centred programs that may include positioning, set-up by staff, adaptive equipment, and cueing. The goal is to promote a resident's ability to function to their full potential thereby increasing their independence and self-esteem. In this way, OTs are valuable members of the restorative care team.

Eating, Feeding & Swallowing

- OTs assess and make recommendations based on a resident's feeding needs to increase independence in feeding or to increase swallowing safety and decrease risk of aspiration. Interventions may include proper mealtime positioning, adaptive feeding equipment, cueing or set-up by staff.

Adaptive Equipment

- OTs assess residents' needs for adaptive equipment, as well as provide education on proper use. These devices may include mobility aids such as wheelchairs and walkers, as well as other equipment such as transfer poles, raised toilet seats, grab bars, reachers, dressing sticks, sock aids, or long-handled shoe horns.

Splinting

- OTs assess for and fabricate splints or recommend pre-fabricated orthotics to maximize and maintain function and range of motion as well as prevent contractures, pain, and further functional decline.

Dementia Care

- OTs use formal and informal cognitive assessments for residents with early onset dementia to monitor changes and ensure their safety and well-being. OTs also address falls prevention strategies and behavioral issues associated with dementia, such as agitation and aggression. Specialized resident programs are developed to provide meaningful activities that maintain cognitive function and reduce disruptive behaviors.

Behavioural Support

- OTs assess the causes of behavioural concerns that can pose an obstacle to care and interfere with a resident's quality of life. OTs can then provide recommendations that will enhance the emotional and psycho-social well-being of residents, enable participation in everyday activities and routines, and decrease caregiver burnout.

Ontario Society of Occupational Therapists

www.osot.on.ca / osot@osot.on.ca / 1-877-676-6768

Occupational Therapy in Long-Term Care

What Occupational Therapists can offer the residents and staff in LTC Homes

OTs enhance quality of life through enabling participation in meaningful, everyday activities!

Mobility & Seating

- OTs assess residents to determine the need for and proper prescription of mobility and seating equipment (e.g. wheelchairs, walkers). OTs determine the correct type and size of chair and appropriate accessories in order to promote resident safety, mobility, participation, and comfort. OTs also re-assess the mobility and seating equipment of residents as changes in their physical and cognitive abilities occur to ensure that equipment continues to meet their needs.

Restraint Reduction

- OTs recommend alternative equipment, techniques, and positioning that reduce or eliminate the need for restraints. OTs also provide strategies for residents who have behavioral issues and who otherwise may have been restrained.

Falls Prevention

- OTs are part of the multidisciplinary team focused on reducing residents' risk of falls. OTs assess resident status and behavioral change and provide interventions such as changes to the living environment (e.g. rearranging bedroom furniture), providing assistive equipment (e.g. grab bars, transfer poles) or addressing their fear of falling.

References
http://www.completerehabsolutions.com/blog/occupational-therapists-in-nursing-homes-part/
http://www.concernedfriends.ca/iOT.htm
http://www.aota.org/Practitioners/Advocacy/Federal/Testimony/2007/40386.aspx?_FT=.pdf

Pressure Wound Prevention & Management

- OTs make recommendations for residents with existing pressure wounds or those who are at increased risk of developing them. Recommendations may include re-positioning schedules, bed positioning, special seating and bedding surfaces or strategies to prevent contractures from becoming more severe.

Resident & Family Education

- OTs educate residents and their family members about skills important for resident safety, participation, dignity, and independence. This may include instruction on proper transfer techniques, positioning, use of a resident's specific mobility or other adaptive equipment or compensatory strategies.

Staff In-Service Training

- OTs can provide a wide range of educational programs to health care staff on topics such as safe transfer techniques, proper usage of adaptive equipment, proper resident positioning techniques or communication strategies for residents with cognitive or sensory impairments.

Connect with Community Resources

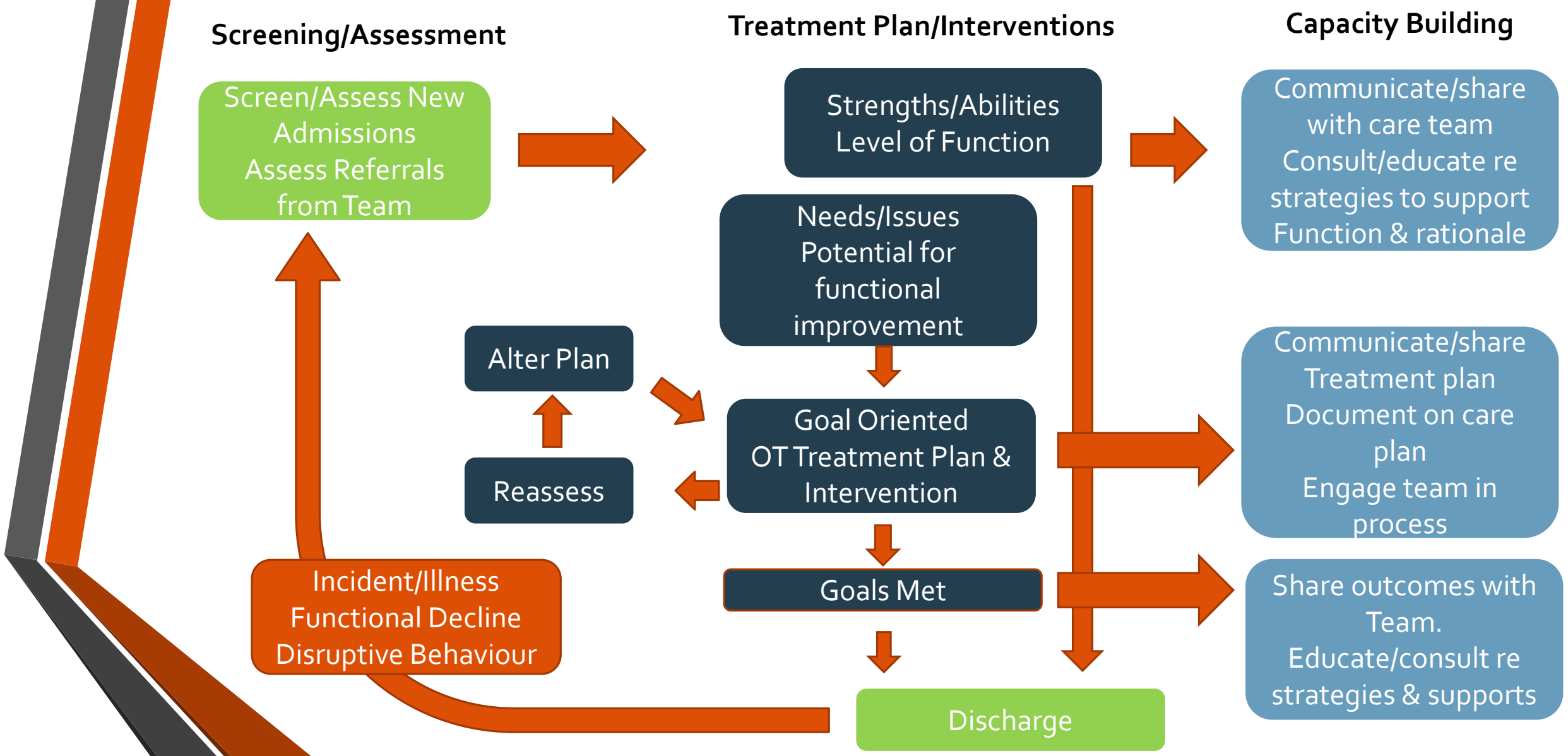
- OTs assess a resident's needs and can support access to community services they would benefit from. These may include services for therapeutic footwear, augmentative communication devices, accessible transportation, compression garments or funding.

OT – a behavioural resource for each home

- Brings specialized skills and perspective to the care team
- Functions as primary contact/lead to BSO Team (or participates on in-home Team)
- "Champion" for attention to residents with cognitive impairment demonstrating responsive behaviours
- Assume Behavioural Lead role….linking with Leads in other homes – communities of practice to support sharing of best practice, etc.
- Provides leadership but also a Team member and frontline treatment staff

Ontario Society of Occupational Therapists

OT Intervention Process



Re-Introducing OT to LTC Homes

- Current State
  - Limited access to OT services in most homes
  - Limited knowledge of full scope of OT, particularly relating to expertise in cognitive assessment (typically familiar with OT role in seating)
  - Sensitivities around "expert" resources amongst team members
  - Limited access to OT has not placed OTs as members of care teams
  - Current service models & hours restrict OT attention to referred clients only (typically seating and mobility only)

Ontario Society of Occupational Therapists

Re-introducing OT to LTC Homes

- Goals
  - Clearly identified role with focus on cognitive function & adaptation
  - Dedicated, consistent OT staff resource, known to care teams
  - OT is recognized team member - collaborates with all staff
  - OT is "doer" not just "assessor"
  - OT able to develop knowledge, familiarity with home (policies, programs, procedures) and residents and families
  - Measurable outcomes for OT service – record-keeping, OT care plans, RAI, additional outcome measures
  - Ability to engage roles and use of OT support personnel (who must work under direct supervision of OT) to maximize cost-efficiencies of service
  - Opportunities for professional networks and OT clinical fieldwork to assure ongoing evolution and resource for sector

Ontario Society of Occupational Therapists

Proposed Model for OT Service Delivery

- **Goal: resident-centred, proactive, preventative, capacity-building interventions focused on residents with cognitive impairment**
- Resource LTC Homes with necessary access to OT services
  - 1 FTE OT per 200 bed LTCH
  - 1 FTE OT Assistant per 200 bed LTCH
  - Designate OT as LTCH's staff resource to mobile BSO Team
  - Engage OT resource to Behavioural, Falls, Restraints, etc. Committees within home
  - Adopt a capacity building approach to care/management of responsive behaviours spearheaded by OT (e.g. Partnering for Change Model)
  - Engage active partnership with university OT programs for fieldwork education

Ontario Society of Occupational Therapists

Rationale for proposed ratio

- PT Funding ratio
- % residents with cognitive impairment
- CIHI data comparators
- Ontario exemplars

Senior received therapy in last 7 days	Percentage of residential care client population			
	Year	B.C.	AB	ON
Physiotherapy	2013/14	11.6%	25.2%	57.7%
	2015/16	12.5%	23.7%	50.0%
Occupational therapy	2013/14	8.9%	22.2%	1.8%
	2015/16	7.4%	18.7%	1.6%
Speech/language therapy	2013/14	0.2%	0.6%	0.4%
	2015/16	0.2%	0.3%	0.3%
Recreational therapy	2013/14	21.8%	42.3%	6.8%
	2015/16	24.1%	33.0%	6.1%

Source: CIHI Quick Stats 2013/14 and 2015/16

https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2016/11/PDT-Update-Report-Final-November-2016.pdf

Ontario Society of Occupational Therapists

Improving Occupational Performance for Clients Living in Long Term Care

Aruna Mitra B.Sc.OT, M.Ed [1], Steven Friesen MEDes[1,3]
Bethany Care Society[1], University of Alberta[3]

ARP Program

The *Bethany Care Society Occupational Therapy Service Model* was developed as part of a quality improvement project. The model provides a foundational framework from which an active rehabilitation approach could be implemented. The goal was to better meet the needs of our residents using an evidence informed, systematic approach to rehabilitation thereby improving occupational performance and quality of life. The model also provided therapists with clear guidelines for conducting an active rehabilitation program.

Introduction

- The number of people with dementia living in long term care is increasing; Alberta 23.2% in 1990 to 60% in 2014/15.
- For residents living in long term care, decreasing mobility and increasing dependency are known to have many adverse effects
  - •increased incidence of pressure sores, contractures, cardiovascular deconditioning, urinary infections, and loss of independence
- Rehab programs can significantly improve cognitive and ADL functioning of people in long term care with dementia (Telenius et al., 2015)
- Physical function and balance improvements have been demonstrated in short (4-wk) task-oriented ambulation training for long-term care residents (Tsaih et al., 2012)
- Longer term (3-mth) occupational therapy and physiotherapy however has indicated no significant effect on mobility and independence (Sackley et al., 2009)

> "*Evidence that physical rehabilitation interventions for elderly people residing in long-term care may be both safe and effective, improving physical and possibly mental state. However, the size and duration of the effects of physical rehabilitation interventions are unclear. Although physical rehabilitation may be beneficial for care-home residents, the specific type(s) with most benefit, and how these relate to resident characteristics, is unclear.*" 2013 Cochrane review, Physical rehabilitation for older people in long-term care.

- 88% of Canadian LTC residents do not receive any rehab and less than 1% of residents received 150 minutes 5 days per week (McArthur et al., 2013)
- Long term care residents spend the majority of their time inactive, with low levels of interaction with staff (Sackley's, 2006)
- While occupational therapists working in long-term care homes focus on resident needs, an outcome of OT service intervention can be the reduction of nursing staff requirement for day to day resident care. (OSOT, 2015)
- Since fully implementing ARP in April 2012, many of our clinicians reported that rehabilitation approaches are positively impacting occupational performance beyond physical function

Method

Assessment Data

- RAI MDS 2.0 outcome scores were selected by clinical leaders to examine impacts of participation in rehabilitation programs in long term care (e.g. level of independence in ADLS, social participation, symptoms of depression and skin integrity).
- Outcome scores were extracted for all long term care residents who;
  - •had at least two Long Term Care RAI assessments completed between April 2012-March 2016;
  - •met the criteria for Rehab RUG (Resource Utilization Group);
  - •received ≥150 minutes per week of rehab services (OT/PT)

Chart Review

- Chart reviews were conducted for residents whose scores had changed during ARP participation and for residents that rehab staff observed increased occupational performance
- Chart reviews examined care plan goals, therapy program details, ADL Kardex, and therapy minute documentation.
- Specific therapist assessment tools (e.g. BERG, TUG) were not included in this review.

Staff Interviews

- Unstructured interviews were conducted with clinical staff (case managers, rehab therapists) to relate and detail impacts of ARP to specific residents

Bethany Active Rehabilitation Programs (ARP)

Program	Goal	Schedule/ Duration
"Goal to Stroll"	Improve physical and emotional aspects of functional mobility (ambulation and wheelchair mobility)	3-5 times/week 30 min session (min) 1:1 or group
"Pump Up the Power"	Improve functional strength, ability to transfer and participate in Activities of Daily Living (ADLs)	2-5 times/week 30 minutes. Group
"Stretch & Flex"	Prevent further decline of ROM in order to provide ease of care and/or reduced pain.	30 minutes 1:1 or Group
"Healthy Minds"	Mediate further decline in cognitive ability, improve symptoms of depression and anxiety and improve performance in ADLs for some residents.	2 week program 30 min session Group

Therapy assistant run, therapist monitored & reassessments quarterly
Groups 1:4 Staff/ Resident ratio

Objective

Using a case based approach, we intended to document the impact of implementing a rehabilitation approach for seniors and young adults with mobility, strength and cognitive limitations living in long term care. Our program review was guided by the following questions:

1. *How can the impact of rehabilitation services (OT/PT) be demonstrated and measured in long term care ?*
2. *Can the impact of a structured active rehabilitation program be effectively demonstrated in RAI MDS outputs (e.g. outcome scores)?*

Results: Occupational Performance

SELF CARE

It makes such a difference for him. He can transfer onto the toilet himself, he does not have to wait 15-20 minutes for a staff member. It's dignified.
She was in a BRODA chair during the day (to off load pressure area). She started with 2 wheeled walker, 2 assistants and went 20 meters. She now walks 100-200 meters with the walker and is working on 1 person standing transfers. Her pressure ulcer is healing.
He went from a Golvo lift to transferring independently with a saska pole. He's starting to walk in the parallel bars. His leg strength definitely has improved.

PRODUCTIVITY ROLE

She is intact cognitively, but struggles emotionally and had poor social skills. She stayed in her room, didn't socialize or engage much. She now participates in the cognitive group. It has had an impact. She has someone to share stories with and made a friend. When her friend was dying she wanted to go to see her. Afterwards she said "I was a good support for her. I was a good friend. I was there to support her.

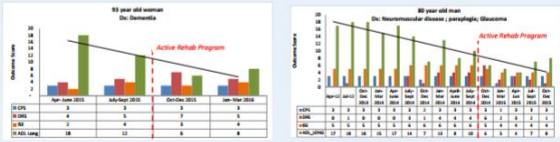
LEISURE

It made a HUGE different for her. She was always tearful, worrying about where her family was, staff would have to reassure and redirect her. She would sit, not engage or participate. Now she seeks out others residents for social contact on her own. She looks forward to the cognitive group. The staff spend less time redirecting her.

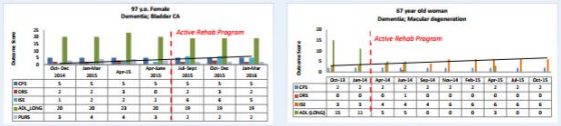
Results: Outcome Scores

- 355 residents across 6 LTC sites participated in ARP from April 2012- March 2016 (based on Rehab RUG #'s)
- 14 charts were examined. The minimum length of participation was 5 months; The maximum was 21 months (M=15.6 SD=4.6)
- Five themes reflected in outcomes scores include:

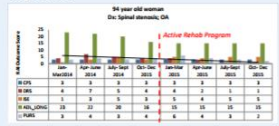
Theme 1: ADL score improved during ARP involvement



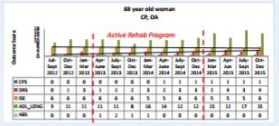
Theme 2: Index of Social Engagement (ISE) score improved during ARP involvement



Theme 4: Aggressive Behaviour Scale improved



Theme 5: Observed clinical change not reflected in score change



Summary of Findings

- The focus in long term care tends to be on enhancing quality of life rather than promoting independence or working toward discharge to another setting.
- Although RAI outcome scores suggest examples of positive impacts of active rehab they don't tell the whole story.
  - Positive changes in outcome scores were seen in many residents but not all
  - Some residents who were reported to have improved function from ARP participation, with no significant changes reflected in outcome scores
- A more complete picture of the impact of rehabilitation on occupational performance requires broader data sources such as interviews with residents, families and staff

Implications

A rehabilitation approach to programs provided to long term care residents may have impacts not clearly indicated using current assessment tools (e.g. RAI-MDS 2.0). This program review suggests the importance of more extensive and longer term measures when considering impacts on occupational performance.

References

Crocker T, Forster A, Young J, Brown L, Ozer S, Smith J, Green J, Hardy J, Burns E, Glidewell E, Greenwood DC. *Physical rehabilitation for older people in long-term care.* Cochrane Database of Systematic Reviews 2013, Issue 2. Art. No.: CD004294. DOI: 10.1002/14651858.CD004294.pub3

Forbes D, Thiessen E.J, Blake CM, Forbes SC, Forbes S. *Exercise Programs for people with dementia.* Cochrane Database of Systematic Reviews 2013, Issue 12. Art. No.:CD006489. DOI: 10.1002/14651858. CD006489.pub3.

McArthur C, Hirdes J, Berg K, Giangregorio L. *Who Receives Rehabilitation in Canadian Long-Term Care Facilities? A Cross-Sectional Study.* Physiotherapy Canada, 2015; 67 (2): 113-21.

OSOT, *Occupational Therapy in Long Term Care homes: Strategies to achieve capacity and meet resident needs,* OSOT Submission to Ministry of Health & Long-Term Care - March 2015, www.osot.on.ca

Sackley C, Wade DT, Mant D, Atkinson JC, Yudkin P, Cardoso K, et al. *Cluster randomized pilot controlled trial of an occupational therapy intervention for residents with stroke in UK care homes.* Stroke 2006;37(9):2330-41.

Sackley C., van den Berg, M., Lett, K. Patel, S., Hollands, S., Wright, C., Hoppitt, T. *Effects of a physiotherapy and occupational therapy intervention on mobility and activity in care home residents: a cluster randomised controlled trial* BMJ 2009 2009;339:b3123

Telenius EW, Engedal K, Bergland A. *Effect of a High-Intensity Exercise Program on Physical Function and Mental Health in Nursing Home Residents with Dementia: An Assessor Blinded Randomized Controlled Trial.* Cameron DW, ed. PLoS ONE. 2015;10(5):e0126102. doi:10.1371/journal.pone.0126102.

bethany®
CREATING CARING COMMUNITIES

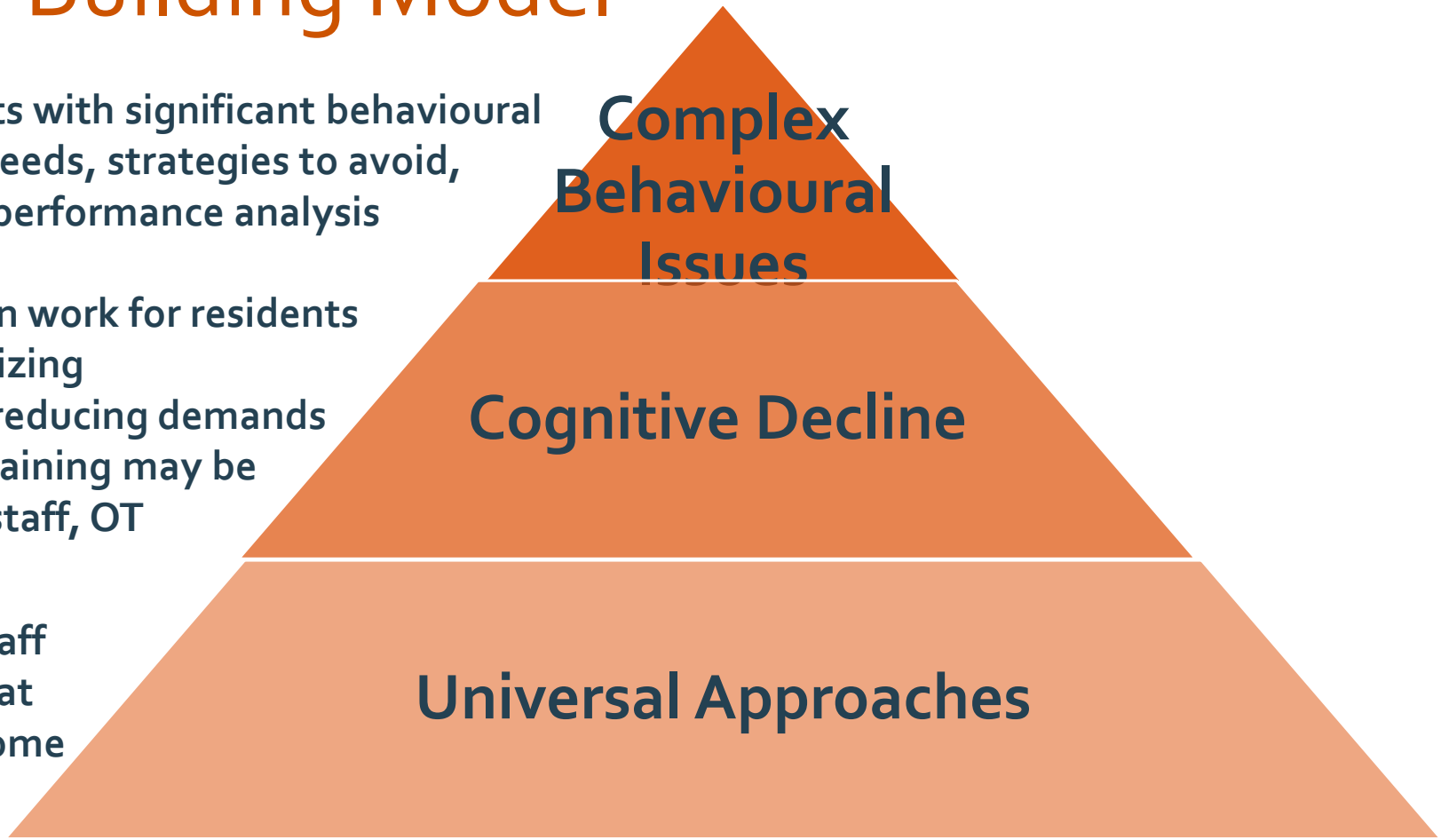
http://www.caot.ca/conference/2016/presentations/w39.pdf

Capacity Building Model

Focused attention to residents with significant behavioural Issues…finding solutions to needs, strategies to avoid, etc. Trial and error, dynamic performance analysis

OTs identify strategies that can work for residents with cognitive decline, maximizing independence, quality of life, reducing demands on care staff – interventions/training may be undertaken by OTAs, nursing staff, OT

OTs work with/consult to home/staff to identify practices, strategies that are good for all but essential for some



Adapted from CanChild's Partnering 4 Change Model https://canchild.ca/en/research-in-practice/current-studies/partnering-for-change an innovative, collaborative, evidence-informed model that uses a needs-based, tiered approach to provide rehabilitation services for children with special needs in schools.

Opportunities of a Capacity Building Approach

- Maximizes utilization of a limited OT resource
- Over time increases capacity of all care staff as they learn through collaboration with OT
- Universal strategies good for all more effectively support residents with mild – moderate cognitive deficits
- Engages all care team & families in strategies to support residents
- All care staff feel supported by OT who is a resource to support staff with difficult behavior management situations

Ontario Society of Occupational Therapists

Potential Funding Models

Resource LTCHs to Hire OT Resource

- Requires dedicated funding envelope for each home with clear goals and outcomes
- Creates LTCH ownership of resource
- OT clearly identified as home team member
- Provides home with designated Lead for behavioural issues/coordination of management approaches
- Relationship to home policies/procedures clear
- Shared model amongst smaller homes in a region may be possible
- Potentially isolating for individual OT – limited professional mentorship/consultation, etc.
- Smaller homes may have difficulty attracting/retaining staff with limited hours
- Clarity of role and focus ideally directed by MOH or LHIN to assure transition to new role/use of OT

LHIN Funds Sub-Region OT Dementia Care Team

- Requires dedicated service funding for OT in LTCHs to serve LHIN or Sub-Regions
- Creates team/resource of OTs focused on cognitive impairment/behaviours in LTCHs in region
- OTs and OTAs must be assigned from Team to designated homes to assure consistent OT presence for any home. Assignment to multiple smaller homes an option
- Opportunity for increased professional networking, shared resource development
- Capacity to cover vacation and sick time priorities may be facilitated
- Propose initial funding of clinical practice lead for regional Team to promote development of consistent approaches across LTCHs, professional development, etc.
- Funding of such a Team through a 3rd party not desired as percentage of funding is directed to profit & is needed to resource homes

Potential Funding Models

- Hybrid options may include:
  - Allocation of OT funding to individual homes but regional/sub-regional funding of a practice lead (at least for first 2 years) to support program development, consistent approaches, orientation/mentoring of new OTs, support to student program – assures investment success
  - Resource model similar to current Psychogeriatric Resource Consultants
- Key issues relate to job security, sufficient hours to maintain staff, support to professional and program development & compensation

Ontario Society of Occupational Therapists

Compensation

- Needs to compete with other sectors – notably hospital sector
- Employment model desirable over independent contractor model
- OT salary range $60,000 - $80,000 ($75,000 - $100,000*)
- OTA salary range $39,000 - $46,800 ($48,750 - $59,950*)
- Salary range needs to recognize experience and advancement potential
- *Employee benefits add 25%
- Based on FTE 37.5 hours/week
- Third party provider payment models have left therapists vulnerable as independent contractors, with unpredictable hours, no benefits and poor hourly rates

Ontario Society of Occupational Therapists

Associated Costs

- Assessment resources and evaluation equipment "tool box" - ~$3000/home
- Reasonable access to computer for reporting purposes
- Office space desirable (shared if part-time)
- Access to quiet assessment/intervention area (does not have to be designated therapy space – although desirable)
- Consider funding of practice lead resource to spearhead local communities of practice
- Consider financial support to development of professional development programs, web-based resources to be developed/offered by the association to offer opportunity to enhance skills focused on prevention/management of responsive behaviours

Ontario Society of Occupational Therapists

Projected Costs

- Based on 640 Ontario LTC Homes & 77,000 beds
- 385 OT and OTA positions - $47,575,000 - $61,600,000
- $1,900,000 in equipment/assessment materials
- Consider
  - Potential to more effectively support nursing – reduce staffing turnover, capacity building proposal to enable homes to more effectively manage with staffing resources – e.g. reduce workload for frontline staff through proactive management of responsive behaviours
  - Potential to reduce costs of wounds, falls, ER admissions, use of psychotrophic drugs
  - Goal to minimize resident on resident violence & related costs & reputational management issues
  - Ability to more effectively meet needs of residents in Long-term Care Homes

Ontario Society of Occupational Therapists

Implementation Considerations

- **Profession's Capacity**
  - Approximately 300 OT graduates each year
  - Job market is tight 30% grads responding to survey identify working multiple jobs to attain full time hours
  - High interest in working with seniors
  - Need stable income, guaranteed hours
  - Experienced community sector OTs would be attracted to a more stable LTCH sector
  - Profession has lost many of its experienced OTs in the LTCH sector as a result of PT Funding Reform – may be able to attract them back
  - Sector's reputation has been challenged by disrespectful employment practices of 3rd Party Providers
  - Keen interest in developing an OT role that works to full scope & is able to make a difference

Ontario Society of Occupational Therapists

Implementation Considerations

- **Professionals' Educational Preparation**
  - Consultation with 5 Ontario schools of OT confirm that all graduating OTs have solid foundation in assessment and interventions for cognitive impairment, dementia and related behaviours and responsive behaviours.
  - Few practicing OTs and graduates have clinical exposure to LTC Homes as a result of lack of positions
  - OTs are skillful collaborators, change agents and team members, well suited to take a frontline/lead role in a home with respect to responsive behaviours
  - Schools willing to consider increased focus to meet system needs
  - Professional development focused specifically on dementia and related behaviours, best practices, etc. could be developed by the association

Ontario Society of Occupational Therapists

Implementation Considerations

- **OT Assistants**
  - Educated at College or private school level as OTA/PTA
  - Currently 70% graduates filter to PTA roles as a result of a lack of OTA roles
  - Marketplace can adapt quickly to needs as private sector able to respond (there is now an accreditation program for private education programs)
  - As OTAs must work under the supervision of a registered OT, there are few OTAs currently working in LTCHs (most graduates work as PTAs in this setting)
  - Relevant educational background in working with seniors, those with cognitive impairment

Implementation Considerations

- Attracting professionals to rural locations, especially if volume of work is limited by size and number of homes
- Opportunity to create networks/community of practice for OTs and OTAs assuming these roles – OSOT can facilitate this
- Potential to evaluate as implemented – staged implementation would enable planned preparation, support to recruits and planned evaluation and metrics
- Need to consider validity of RAI MDS as a measure of OT in LTCHs – are there other measures that could be introduced to augment data collection to measure outcome?
- Opportunities for collaborative research – academic community has expressed some interest
- Need to build in capacity for student fieldwork experience – builds capacity and expertise within profession – all schools are very keen to work to engage

Ontario Society of Occupational Therapists

Resources/References

- Ontario Society of Occupational Therapists. **Occupational Therapy in Ontario Long-Term Care Homes – strategies to achieve capacity to meet resident needs, March 2015**
- Ontario Society of Occupational Therapists**. Occupational Therapy in Long-Term Care, 2012**
- NICE Clinical Guidelines, No. 42.National Collaborating Centre for Mental Health (UK). **Dementia: A NICE-SCIE Guideline on Supporting People With Dementia and Their Carers in Health and Social Care.** Leicester (UK): British Psychological Society; 2007.
- Gutmanis, I., Snyder, M., Harvey, D., Hillier, L. M., and LeClair, J. K. (2015). **Health Care Redesign for Responsive Behaviours – The Behavioural Supports Ontario Experience: Lessons Learned and Keys to Success**. Canadian Journal of Community Mental Health, 34(1), 45-63.
- Moniz Cook ED, Swift K, James I, Malouf R, De Vugt M, Verhey F. Moniz Cook ED. **Functional analysis-based interventions for challenging behaviour in dementia**. Cochrane Database of Systematic Reviews 2012, Issue 2.
- Herrmann, N. **Recommendations for the management of behavioral and psychological symptoms of dementia** Can J Neurol Sci. 2001 Feb;28 Suppl 1:S96-107.
- Laura N. Gitlin, Ph.D., Director,[1] Laraine Winter, Ph.D., Assistant Director,[2] Marie P. Dennis, Ph.D., Ed.M., Assistant Director,[2] Nancy Hodgson, Ph.D., RN, Research Analyst,[3] and Walter W. Hauck, Ph.D., Statistical Consultant[4]. **Targeting and Managing Behavioral Symptoms in Individuals with Dementia: A Randomized Trial of a Nonpharmacologic Intervention**. J Am Geriatr Soc. 2010 Aug; 58(8): 1465–1474.
- J. Cerejeira,[1,*] L. Lagarto,[1] and E. B. Mukaetova-Ladinska. **Behavioral and Psychological Symptoms of Dementia.** Front Neurol. 2012; 3: 73.
- Alzheimer's Association (US). **Dementia Care Practice Recommendations for Assisted Living Residences and Nursing Homes.** 2009
- Maddocks, Ian. The Community Hub: a proposal to change the role of Residential Aged Care Facilities (RACFs), Family Medicine and Community Health 2014;2(4):20–25
- Davidson, S. Dementia: a systematic approach to understanding behaviour. Geriatrics & Aging, 2007, 10(2):104-107

Ontario Society of Occupational Therapists