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

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• **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.
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)
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
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
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
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
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
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
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
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-handed 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
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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 reassess 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.

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.

References:
http://www.consumeraffairs.ca/otr/otnr  
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
OT Intervention Process

Screening/Assessment
- Screen/Assess New Admissions
- Assess Referrals from Team

Alter Plan
- Reassess
- Incident/Illness
- Functional Decline
- Disruptive Behaviour

Treatment Plan/Interventions
- Strengths/Abilities
- Level of Function
- Needs/Issues
- Potential for functional improvement
- Goal Oriented OT Treatment Plan & Intervention
- Goals Met

Capacity Building
- Communicate/share with care team
- Consult/educate re strategies to support Function & rationale

- Communicate/share Treatment plan
- Document on care plan
- Engage team in process

- Share outcomes with Team.
- Educate/consult re strategies & supports

Discharge
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)
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
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
Rationale for proposed ratio

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

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<th>Senior received therapy in last 7 days</th>
<th>Percentage of residential care client population</th>
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Source: CIHI Quick Stats 2013/14 and 2015/16

Improving Occupational Performance for Clients Living in Long Term Care

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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 focus is to better meet the needs of our residents. The multidisciplinary approach to rehabilitation therapy can improve occupational performance and quality of life. The model also provides 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 20.2% in 1996 to 26% in 2014.
• For residents living in long term care, increasing mobility and increasing dependency is known to have adverse effects.
• The presence of arthritis, osteoarthritis, deconditioning, urinary incontinence, and loss of independence.

• Rehabilitation programs can significantly improve cognition and ADL functioning of people in long term care with dementia (Friesen et al., 2011)
• Physical function and balance improvements have been demonstrated in short (4-6 week) task-oriented intervention training for long-term care residents (Thal et al., 2012).

Objective

Using a case-based approach, we examined the impact of implementing a rehabilitation approach for seniors and young adults with mobility, strength, and cognitive limitations living in long term care. Our research program 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 residents living in long-term care?

Method

Assessment Data

• RAI MDS 2.0 outcome scores were selected by clinical therapists 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 anxiety).

• Outcome scores obtained for all long-term care residents with the RAI MDS 2.0.

• Staff assessments of all rehabilitation residents completed between April 2013 - March 2014.

Analysis

• Data were entered into a database using Microsoft Excel and compared using paired-samples t-tests.

• The data were analyzed using R software.

Results: Occupation Performance

DEFINITION

A rehabilitation approach that focuses on activities of daily living and the independent use of mobility aids.

• Occupational measures of performance (O-MPO)
• Activity performance (O-AP)

• Participation in rehabilitation therapy with activities

SUMMARY

The occupational performance of residents living in long term care was significantly improved with the implementation of the Alberta Rehabilitation Program. The program demonstrated positive effects on residents' occupational performance and quality of life.

References


Implications

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

Complex Behavioural Issues

Cognitive Decline

Universal Approaches

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

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

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

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
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
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
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
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
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
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
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.
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

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