Input to Long-Term Care Home Staffing Review

Ontario Society of Occupational Therapists

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Executive Summary

Occupational therapists (OTs) are regulated health professionals who assist people to overcome or minimize barriers to managing the day to day tasks, activities and interactions of their lives when health related issues limit function**.** Occupational therapists are masters prepared professionals who bring a background in both physical and mental health with attention to functional capacity, performance and engagement in occupations (activities) that people need and want to do.

Addressing the "Right" staff mix in Ontario's Long-Term Care Homes

While the most publicly visible staffing crisis in long-term care is a shortage of personal support workers and nursing staff, attention to the interprofessional supports available to address resident needs must be a priority as well. Occupational therapists are absent or minimally represented on interprofessional teams in Ontario's long-term care homes (LTCHs); indeed Ontario has the lowest percentage of resident access to OT across Canada. Attention to the inclusion of occupational therapists in the LTCH staff team would bring supports to;

- address resident needs,
- mitigate risks to residents that can result in increased care demands,
- bring new skills and perspectives to the challenges of managing responsive behaviours or mental health conditions
- complement the interprofessional team's diversity of approach and knowledge applied to the day to day problem solving required to manage complex residents in a challenging environment
- contribute to the building of staff capacity to better manage the complex needs of residents

Resident-focused occupational therapy interventions are targeted to:

- prevent de-conditioning and promote sustainable levels of function for as long as possible
- restore function when impaired by periodic injury, illness or other factors
- promote adaptation when cognitive abilities are impaired in order to improve function and/or reduce behavioural episode related to loss of independence or control
- improve quality of life and engaged participation in the restorative care environment and activity of the home
- assess and intervene to mitigate resident risk relating to;
    - cognitive behavioural status which may result in wandering, outbursts, etc.
    - falls
    - skin breakdown and other wounds associated with poor skin integrity
    - use of restraints
    - environmental accessibility
    - mental health status
- adapt/modify the resident's living environment to optimize function and safety

Occupational therapists make impactful contributions to a LTCH's attention to key indicators of quality resident care

CIHI data reflects that Ontario's long-term care homes are making gains in some quality indicators, however, resident falls continue to increase. While this impacts the resident most significantly, falls result in increased health system costs and increased demands on LTC home staff. Occupational therapists are key professionals in falls prevention strategies; we outline specific contributions.

Occupational therapists can address resident needs that reduce the demand on care staff and/or prevent additional resident care requirements by;

- Mitigating Responsive Behaviours
- Improving Resident Functional Ability to Minimize Care Demands
- support early attention to prevention of:
  - Ulcers and sores
  - Mobility Needs
  - Safe Transfer techniques
  - Restorative Approaches

Restoring access to OT Services...a step toward achieving the "right" mix of LTCH Staffing

Percentage of Residents assessed to have Occupational Therapy Interventions

Newfoundland/Labrador	**9.3%**	**Manitoba**	**3.4%**	**Saskatchewan**	**2.2%**
Alberta	**17%**	**British Columbia**	**6.3%**	**Yukon**	**10.4%**
Ontario	**1%**				

Every resident of an Ontario long-term care home has a right to access occupational therapy services when they can benefit from these services. The LTCHA requires that homes provide access to necessary therapy services and further commits to a philosophy of restorative care. Occupational therapy can not only address resident needs but will also contribute to achievement of performance indicators, reduction in care needs, and cost savings.

Adding to the interprofessional mix of staffing in a long-term care home in a strategic way can also be supportive to capacity building amongst all staff, provide more effective support to all nursing care staff, and improve resident care planning and interprofessional problem solving.

To ensure limited financial resources are expended most fully to resident care, OSOT promotes engaging occupational therapists in an employment model that eliminates the percentage paid to third party operators. An employment model would serve to commit dollars to resident care and would enable fairer compensation for occupational therapists working in the sector.

OSOT recommends that all residents of long-term care homes have access to occupational therapy services funded at a minimum of 21 hours/week for a 200-bed facility.

Introduction

The Ontario Society of Occupational Therapists (OSOT) applauds the government's commitment to review staffing in Ontario long-term care homes with a goal to develop a comprehensive staffing strategy for implementation by the end of 2020. While staffing is but one component of many that contribute to the delivery of quality care that is resident-focused and that meets the needs of each individual resident and the safety needs of all residents, it is a critical factor. Ontario's *Long-Term Care Homes Act, 2007 (LTCHA)*, asserts the fundamental principle that a long-term care home is primarily the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met. As the resident profile in Ontario LTCHs continues to become more complex with over half of residents over the age of 85, 90% with some form of cognitive impairment and 86% with need for extensive assistance with basic activities of daily living such as eating, dressing or toileting[1], residents' dependence upon, and interaction with, staff is ever more present. Residents need access to qualified, skilled, caring, consistent staff who are committed to providing good care but also to respecting and enabling the concept of "home" that the *LTCHA* prescribes. The diverse needs of today's residents require diverse professional perspectives and skills; the interprofessional approach to care espoused to in the Act is more critical than ever. We are pleased that the government's study will explore issues relating to the staffing models and skill mix to support both current and future needs.

The Ontario Society of Occupational Therapists (OSOT) is the voluntary professional association of Ontario Occupational therapists representing over 4500 members.

Occupational therapists (OTs) are regulated health professionals who assist people to overcome or minimize barriers to managing the day to day tasks, activities and interactions of their lives when health related issues limit function. OTs work with clients across the lifespan and work across the continuum of our public health system – from primary care to long-term care. Occupational therapists are masters prepared professionals who bring a background in both physical and mental health with attention to functional capacity, performance and engagement in occupations (activities) that people need and want to do.

Do we have the "right" staff mix in Ontario's Long-Term Care Homes?

While the most publicly visible staffing crisis in long-term care is a shortage of personal support workers and nursing staff, attention to the interprofessional supports available to address resident needs must be a priority as well. The "right" mix of staff serves to enable each staff member to work to the fullness of their scope and to manage realistic workloads. When the demands for resident care are not met, there are two ways to intervene – increase staff to care for residents or reduce the care demands on

[1] Ontario Long-Term Care Association. This is Long-Term Care 2019. Retrieved at https://www.oltca.com/OLTCA/Documents/Reports/TILTC2019web.pdf

staff. We believe that critical attention to both strategies is necessary.   To, this end, we submit recommendations for increased access to Occupational therapy services to;

- address resident needs,
- mitigate risks to residents that can result in increased care demands,
- bring new skills and perspectives to the challenges of managing responsive behaviours or mental health conditions
- complement the interprofessional team's diversity of approach and knowledge applied to the day to day problem solving required to manage complex residents in a challenging environment
- contribute to the building of staff capacity to better manage the complex needs of residents

Occupational therapy – a valued resource for long-term care homes

Occupational therapy is a relevant and important service for long-term care homes who are directed by legislation to engage in a restorative approach to care that promotes residents' well-being and quality of life in an environment that is recognized to be their home. Occupational therapy services are directed to promote resident function and engagement, however, the profession also makes meaningful contributions to the prevention of risks such as falls, pressure wounds, depression, or responsive behaviours of residents with severe dementia.

Resident-focused Occupational therapy interventions are targeted to:

- prevent de-conditioning and promote sustainable levels of function for as long as possible
- restore function when impaired by periodic injury, illness or other factors
- promote adaptation when cognitive abilities are impaired in order to improve function and/or reduce behavioural episode related to loss of independence or control
- improve quality of life and engaged participation in the restorative care environment and activity of the home
- assess and intervene to mitigate resident risk relating to;
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    - use of restraints
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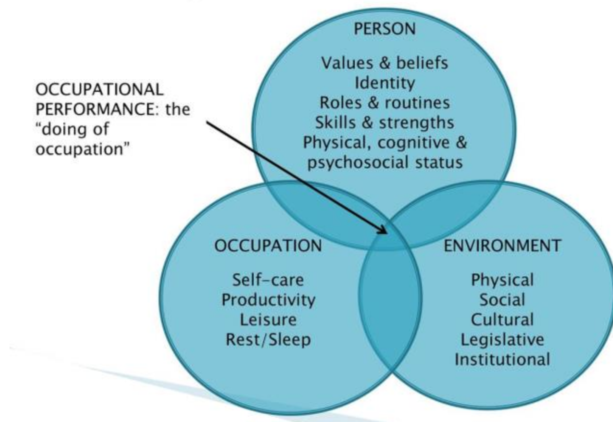
View Appendix 1 (page 13) for a quick summary of key foci of occupational therapy interventions in long-term care.



Occupational therapy is based on a foundational understanding of the relationship between the person (their strengths and abilities), the occupation or task demands of what they need or want to do, and the environment in which they need to function.[2] OTs works to maximize a person's abilities, to provide adaptations that enable the occupation they need to do when, and to modify the environment in which one needs to function if this will promote more effective function. With a focus on the *whole* person – their physical, cognitive and mental health status in the context of their environment, occupational therapists address many of the most complex and challenging issues residents present.

Occupational therapists work as members of interprofessional teams, contributing and consulting to the problem-solving, treatment planning and day to day resident care. An OT perspective on key policy and program committees within a home is a valued addition in such areas as falls prevention, wound care and prevention, restraint reduction programs, behavioural management strategies, pain management, etc.

Why add Occupational Therapy to the staffing mix in long-term care homes?

Every resident of an Ontario long-term care home has a right to access to OT services. The LTCHA requires that homes provide access to necessary therapy services. And yet, many homes across the province have no access to OT services or such minimal provisions that there is limited potential for OTs to meaningfully address the needs of all residents who are referred to the service. There is a need to re-establish occupational therapy as part of the core staffing mix in long-term care homes. We outline 3 reasons this can be an important component of addressing Ontario's long-term care home staffing crisis:

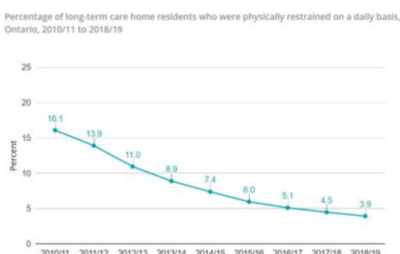
- **Occupational therapists make impactful contributions to key indicators of quality resident care – e.g. resident falls**
- **Occupational therapists can address resident needs that reduce the demand on care staff and/or prevent additional resident care requirements**
- **Access to OT services is diminished if not absent in long-term care homes in Ontario further to physiotherapy funding reform in 2013**

[2] Law et al. The Person, Environment, Occupation Model: a transactive approach to occupational performance. Canadian Journal of Occupational Therapy, Vol 63, #1, 1996. Retrieved at https://s3.amazonaws.com/academia.edu.documents/36405143/Mary_Law_PEO_model.pdf?response-content-disposition=inline%3B%20filename%3DMary_Law_PEO_model.pdf&X-Amz-Algorithm=AWS4-HMAC-SHA256&X-Amz-Credential=AKIAIWOWYYGZ2Y53UL3A%2F20200228%2Fus-east-1%2Fs3%2Faws4_request&X-Amz-Date=20200228T092734Z&X-Amz-Expires=3600&X-Amz-SignedHeaders=host&X-Amz-Signature=ed007b92fb22f97ccb387e8cc0a742479c5c256fc148324b4f95d600bf687d2a

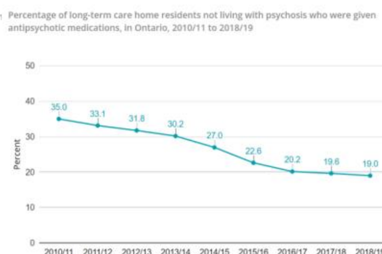
Occupational therapists make impactful contributions to a LTCH's attention to key indicators of quality resident care

Review of CIHI data relating to Ontario LTCH performance between 2010/11 and 2018/19 would suggest that homes are achieving improved results in reducing use of restraints and inappropriate use of anti-psychotic medication. However, over the same period, data identify an increase in the percentage of residents who fall. [3]

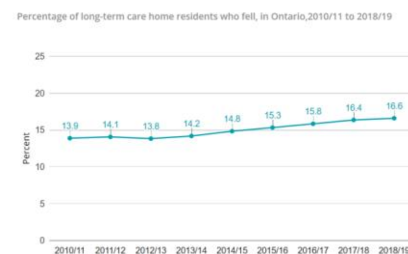
% of residents physically restrained on a daily basis



% of residents not living with psychosis who were given anti-psychotic medication



% of residents who fell



To an Occupational therapist this tells three stories:

- First and most important, homes are not addressing root causes of resident falls. While inappropriate restraints and medication can be used to keep residents from falling, if these are removed without addressing the reasons that residents are falling, it's not unexpected that falls will increase. Of note, CIHI data from Saskatchewan reflects there remain high percentages of residents secured by physical restraints and a higher use of anti-psychotic medication but the percentage of resident falls is lower.

- LTCHs are not currently resourced with a staffing mix that can appropriately address the root cause of falls. To a point, most LTCHs do not have access to Occupational therapy services and those that do have such limited access (typically in a range of 3-5 hours a week for a 200 bed facility) that attention to the full scope of resident needs is not possible.

- Not only are residents at an increased risk of fall in Ontario LTCHs but both the home and the health system are also at risk of increased cost as a result of increased falls that result in emergency department visits and/or surgery and hospital admission and/or increased post-fall or post-surgical care demands on LTCH staff

Occupational therapists are a skilled resource that focuses on the resident and the big picture – what are the resident's capabilities, what do they need or want to do, how does the environment in which they need to function impact them. In relation to falls, specific OT interventions would include:

- **Assessment/provision of appropriate seating and wheelchair mobility**

[3] Heath Quality Ontario. Long-Term Care Home Performance, 2020. Retrieved from https://www.hqontario.ca/System-Performance/Long-Term-Care-Home-Performance

  - Addressing comfort, pain reduction, etc. that contribute to residents wishing to get out of their chair which poses the risk of falls
  - Assessing capacity for and supporting functional mobility to address issues (e.g. frustration with lack of independent mobility) that can cause residents to get out of their chair or bed
  - Assessing and providing individualized solutions to position residents to support a resident for interaction and function (e.g. feeding) but minimizes potentials for falls (e.g. allows for positioning in dynamic tilt that can reduce potential for residents to slide out of chairs).
  - OTs deal with complex seating and are well-suited to be the ADP authorizer in a LTC home – assessment and interventions/solutions are individualized and uniquely focused on a resident's needs beyond mobility, including effective positioning at meals to reduce aspiration risk, accommodate kyphotic posture, wheelchair design to facilitate transfers/toileting and function within existing environment.

  The overall benefit of investing in expertise to address seating and positioning include:

  - Reduce falls
  - Support functional ADL to the resident's potential
  - Mitigate potential for pressure sores and pain which result from inappropriate seating/positioning
  - Improve resident quality of life

- **Assessment & training/consultation re transfer techniques**
  Most falls occur while a resident is moving from one surface to another – chair to/from toilet, chair to/from bed. OTs can assess a resident's ability to transfer, the need for adaptation or assistive devices to make transferring safe and can consult to staff re. safer transfer techniques to promote resident safety and reduce staff risk of harm. Promoting and supporting functional independence is important when a resident has the assessed ability. At the same time, when a resident is not able to safely manage day to day living skills and care must be provided, it is important to address strategies that can reduce both time and risk of harm to nursing staff. Occupational therapists address these issues. For example;
  - Appropriate railings in a bathroom and supports at the bedside to meet the individual resident's needs/abilities can facilitate safe transfers and can reduce the demand on nursing staff to facilitate the resident's transfers/toileting. In such an example, the resident may progress to transfer independently or with one instead of two nursing staff.

- **Assessment of cognitive function and impact on resident mobility**
  Occupational therapists are important assessors of cognitive function, particularly as this relates to function. OTs are important resources to teams to determine how a resident's cognitive function might affect their safe mobility. Residents who experience significant dementia and are unable to communicate their needs may become agitated to move increasing risk of fall.

Occupational therapists are skilled in identifying triggers for agitation (e.g. pain, boredom,) and provide strategies to mitigate these triggers.

Attention to falls reduction is critical to improve resident experience and is an important indicator of a long-term care home's performance. Falls prevention is also an important strategy to reduce costs both within the home and in the system, cost savings that can be re-directed to staffing. Osteoporosis Canada reports that 44% of LTCH residents are at high to very high risk of fracturing a bone as a result of a fall.[4] A common falls injury amongst residents is a hip fracture. Osteoporosis Canada reports the costs of a hip fracture based on a Canadian average based on 2010 dollars at $25,700.[5]

Average unit cost	Hip
Emergency Room visits	$1,524.00
Hospitalizations	$20,068.00
Same Day Surgery	$4,147.00

Based on these figures of the average cost of a hip fracture in 2010 dollars, prevention of 4 hip fractures would cover the costs of a full-time occupational therapist in a home of 180 – 200+ beds, including benefits.

Occupational therapists can address resident needs that reduce the demand on care staff and/or prevent additional resident care requirements

Today's long-term care home resident is increasingly complex and requiring of nursing care. The potential to reduce the demands on a limited number of nursing staff is important to explore. Occupational therapists can bring a new perspective to the interprofessional team that can reduce patient care loads in the following ways:

1. Mitigating Responsive Behaviours

The Ontario Long-Term Care Association reports that 90% of LTCH residents have some level of cognitive impairment and 1 in 3 residents has serious cognitive impairment. For persons living with dementia, the confusion, fear and frustration that can result from a unmet needs between what the person hopes to achieve, their abilities, and their environment can be a significant contributor to responsive behavior. Occupational therapists work with these domains and possess key assessment, enablement, treatment, and evaluation skills that align with current best practices with this population. We append *Occupational Therapy and Behavioural Symptoms of Dementia* as Appendix II (page 15) to provide more detail on the role of occupational therapy and responsive behaviours and the fit of the profession with both the PIECES framework and Behavioural Supports Ontario.

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[4] Osteoporosis Canada. *Fracture Risk Factors for LTC Residents.* 2018. Retrieved at https://www.fco.ngo/sites/default/files/Fracture%20Risk%20Factors%20for%20LTC%20Residents%20infographic.pdf

[5] Osteoporosis Canada. *Make the FIRST break the LAST with Fracture Liaison Services, Appendix B, Fracture Incidence and Costs by Province*, October 2013. Retrieved at https://www.osteoporosis.ca/wp-content/uploads/Appendix-B.pdf

Occupational therapists provide individualize assessments to determine triggers – often discomfort, pain inability to communicate a need, lack of mobility, etc. – and then to address these factors with a goal to reduce behaviours that are disruptive to staff and other residents and staff and are demanding of staff time to address.

2. Improving Resident Functional Ability to Minimize Care Demands

As part of the interprofessional team, OTs work with residents and staff to maximize resident functional ability and enable independence when possible or to minimize care demands. Occupational therapists work with a focus on activities of daily living – feeding, grooming, toileting, dressing and mobility. Assessing a resident's strengths and abilities (physical and cognitive) the OT can determine potential for safe independence and interventions can focus on skills training, introduction of assistive devices or equipment to support function or modification of the environment in which the resident needs to function. For example:

- A resident with a severe kyphosis needs to be positioned in a seating system to ensure his face is in neutral position for feeding to avoid aspiration. Once the OT has addressed appropriate seating/positioning, the introduction of adapted utensils, plate guards and cups can enable independent feeding for a resident previously fed.

- Enabling mobility in a wheelchair, e.g. with feet to get to dining room or to move from location to location with autonomy, enabling social interaction and reduce staff time required to move resident from place to place.

Today 86% of residents are reported to require significant care needs for ADL. Any potential to safely reduce the care time required can be important to managing staff demands, morale, etc.

3. Building capacity of all team members to address functional needs and to employ risk mitigating or function enabling strategies

As is common in most interprofessional teams, professionals learn from each other enriching their professional range of competence. An integrated functional team is able to be more proactive and preventative in approach. Occupational therapists working within a home are well positioned to share strategies that work with individual residents and to reinforce practices that promote safe function, autonomy and quality of life. This shares perspectives, skills and competencies that can be employed by nursing staff. This can have an impact on reducing incidents that cause harm/discontent for residents and increased staff workloads or costs to the home.

4. Routine access to occupational therapy as part of the team can support early attention to

- Risks of pressure ulcers or prompt prevention of sores getting worse
- Mobility needs to maintain independent mobility
- Safe transfer techniques
- Staff inservices on maintenance & restorative approaches.

- Reducing the demand for care contributes to quality of care by enabling staff to spend more time with residents
- Staff morale, reduced turnover - staff-feel they have additional support,

Where is OT in Long-Term Care Homes Now?

While occupational therapy was a fixture in long-term care homes in the past, decisions of the previous government relating to physiotherapy reform in 2013, had the unintentional consequence of eliminating the access to OT services that most homes relied upon. Although a LTCH's Program and Support Services funding was intended to fund support services like occupational therapy, PT provider clinics offered complimentary OT services and homes readily took advantage of options to reduce their costs. When PT provider contracts were restructured with increased accountability, they were not able to provide services outside the contract; unfortunately, LTCHs had found other regular use for PSS envelope funds that were previously used for OT.

Today, many homes provide no access to OT services. A few may employ an occupational therapist but most contract externally for minimal hours – 3 – 5 hours /week for a home of approximately 200 beds (as reported by OSOT member inputs). The present limitation of hours for OT services results in a visit model where an OT is in a home 1 day per week for a few hours. This provides little opportunity for continuity of or full scope of care and elongates timelines for interventions and resolution of issues. The following are typical illustrations:

- A resident develops skin breakdown the day after an OT's weekly visit. The OT cannot make an assessment of a client's pressure relief/equipment needs until the next week. This can result in further tissue breakdown and longer healing times that require attentive additional nursing care and associated expenses (nursing hours and wound care supplies).
- A new resident is admitted 2 days after the occupational therapist's weekly visit and arrives in a transport wheelchair with no positioning supports which she is unable to propel. The OT is unable to assess until the following week to determine appropriate seating and safe mobility. This can result in skin breakdown, falls resulting when residents attempts to transfer or be independently mobile.

Such minimal access results in the OT's ability to address only the most pressing of residents' needs. As there is little administrative, nursing, or family member tolerance for waitlists for OT services for LTC residents, OTs regularly work beyond funded hours to minimally meet resident needs. Further, in the contractual arrangements of OTs, the ability to participate as a full member of the team is restricted both by hours and what one is contracted to do. In short, there is little capacity for an OT to work to full scope, to integrate their services with those of the Team, to contribute to team processes, and to be most effective in improving resident care and the resident's experience of living in the home.

Current day access to OT services in LTCHs in Ontario falls far short of levels of access in other provinces as evidenced by the CIHI data.[6] CIHI reports a Canadian average of 4.2% of residents who were assessed

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[6] CIHI. *Profile of Residents in Residential and Hospital Based Continuing Care. CCRS Quick Stats 2018 – 2019*, Retrieved at https://www.cihi.ca/sites/default/files/document/ccrs-quick-stats-2018-2019-en.xlsx

to receive occupational therapy services in residential continuing care. Ontario LTCHs reported 1% of residents were assessed – the lowest ratio of OT interventions to resident across the country! Ontarians deserve better.

Percentage of Residents assessed to have Occupational Therapy Interventions

Newfoundland/Labrador	9.3%	Manitoba	3.4%	Saskatchewan	2.2%
Alberta	17%	British Columbia	6.3%	Yukon	10.4%
Ontario	1%				

Restoring access to OT Services...a step toward achieving the "right" mix of LTCH Staffing

Every resident of an Ontario long-term care home has a right to access occupational therapy services when they can benefit from these services. The LTCHA requires that homes provide access to necessary therapy services and further commits to a philosophy of restorative care. Occupational therapy can not only address resident needs but will also contribute to achievement of performance indicators, reduction in care needs, and cost savings. Adding to the interprofessional mix of staffing in a long-term care home in a strategic way can also be supportive to capacity building amongst all staff, provide more effective support to all nursing care staff, and improve resident care planning and interprofessional problem solving.

To ensure limited financial resources are expended most fully to resident care, OSOT promotes an employment model, that eliminates the percentage paid to third party operators. An employment model would serve to commit dollars to resident care and would enable fairer compensation for OTs working in the sector.

Present compensation levels and hours allocated to contracts are poor motivators for long service in the sector. Contracts are often resourced with new graduates or internationally educated OTs who are disadvantaged in the marketplace but have a goal to move on to employed positions as soon as possible, compromising the possibility of continuity of care. This is particularly concerning because they have little experience in the system.

OSOT recommends that homes provide a minimum of 21 hours/week of occupational therapy services for a 200 bed facility (fulltime would be ideal).

The Society recognizes the fiscal impacts of increasing staff resources. However, the solution to resident safety and quality of life issues in LTCHs requires an investment. We stress that an upfront investment in occupational therapy can contribute to cost savings to the home and the health system which, over time, can compensate for the expense. For example;

- Cost of a hip fracture that results in hospitalization cost $25,700. If attention to additional falls prevention strategies through OT contributed to a reduction of even 4 falls/year, the cost of the OT would be covered

- It has been stated that the complexity of today's LTCH resident requires significant care for basic ADL, positioning and mobility needs. The care requirements are magnified when disruptive behaviours, a pressure ulcer, a fracture, impact residents' ability to function. Occupational therapists focus both on maximizing resident function to diminish care demands, but also on reducing risks associated with incidents that result in increased care requirements. (responsive behaviours, pressure ulcers, falls, accessibility, etc.)

- The addition of occupational therapy to the interprofessional staff team allows for cross-pollination of professional perspectives and skills. OTs can contribute to the capacity building and strengths of team members. A team that has diverse skills can be more nimble and effective in addressing the complexity of today's long-term care home resident.

Why an Employment Model?

Building a resource of occupational therapy *within* a LTCH is a critical strategy when providing access to these services. Externally contracted therapists have little flexibility, are typically not engaged in care planning meetings because they may not be in the home at the time and have less opportunity to build the collegial and trusting relationships with other staff in the home that is so important to collaborative, resident-focused, interprofessional care.

From the profession's perspective, employing occupational therapists in long-term care homes is also critical to build expertise and capacity within the profession. Retention is a challenge in the sector currently and, in a sector where team members have to work together to address very complex clients, this poses additional barriers to quality resident care. The capacity of an occupational therapist to engage support personnel to augment OT service access is not feasible in today's current contracted model. There is not time to assess and appropriately assign components of complex care to assistants. Further, the profession is unable to train student occupational therapists in long-term care homes because supervising OTs are not accessible. We know that providing students the opportunity to learn and work in long-term care can positively impact interest in the sector.

Continuing the dialogue…

The Ontario Society of Occupational Therapists is pleased to make this submission to contribute to the review of staffing needs in Ontario's long-term care homes. We look forward to a continuing dialogue to explore further how occupational therapists can best add value in LTCHs and to engage strategies to restore reasonable levels of access to LTCH occupational therapy services that can add value to residents, long-term care homes and the health system.

Please contact Christie Brenchley, Executive Director at cbrenchley@osot.on.ca /416-322-3011.

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.

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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.

Occupational Therapy and Behavioural Symptoms of Dementia

Introduction

Occupational therapy is a person-centered health profession concerned with promoting health and well-being through enabling participation and engagement in the activities of everyday life, across the lifespan. The role of occupational therapy in promoting the health and well-being of aging Ontarians, and individuals with dementia or other forms of cognitive impairment in particular, has been a growing interest among occupational therapists, researchers and policy makers alike.

The purpose of this paper is to review the current context of care for persons with behavioural symptoms of dementia, and the unique opportunities offered by the profession of Occupational Therapy to advance management of this challenging issue in long-term care homes in order to enable the quality of life of residents and to provide more effective support to address impacts of challenging behaviours on staff. The goal of the occupational therapist's assessment, treatment and leadership in this practice area is to;

- Identify underlying needs and issues that give rise to responsive behaviours in order to address these with a goal to supporting the resident's quality of life and preventing or minimizing the frequency of future disruptive behaviours.
- Support capacity building within the resident care team to address prevention/management of behavioural symptoms of dementia.
- Reduce consequences of responsive behaviours such as falls, ER visits, resident risk, resident on resident violence, etc.
- Support care team as a resource for behavioural issues, impacting workload by reducing time spent in addressing disruptive behaviours.

Population and environmental context

In 2012, older adults aged 65 and older represented 14.6 percent of Ontario's total population [1]. According to Dr. Samir Sinha, Provincial Lead for Ontario's Senior Strategy, this number is expected to double in the next twenty years. The estimated prevalence of dementia within this population of older adults is equally striking. The Alzheimer Society reports that, as of 2016, there are 564,000 Canadians living with dementia [2]. By 2023 this number is expected to rise 66%, to 937,000. Older adults with complex needs account for 60 percent of health care spending annually [1]. If left unaddressed, Dr.

Sinha writes, “our demographic challenge could bankrupt the province” [3].

Behavioural symptoms of dementia, or responsive behaviours, have been found to be present in between 56-90% of community dwelling individuals with dementia and from 91-96% of individuals in hospital and long term care settings[4]. The term responsive behaviour refers to any behaviour demonstrated by a person with dementia or other progressive neurocognitive disease[1] that occurs in response to a real or perceived internal or external stimulus. These behaviours, which include symptoms of restlessness, pacing, verbal and physical aggression are associated with poor quality of life, and can result in greater use of mechanical restraint and psychotropic drug use [4-6].

Further, behaviours in dementia have been associated with:

- Increased caregiver stress, illness and burnout [4, 7-9]
- Increased functional impairment [4]
- Faster progression of disease[4]
- Greater rates of institutionalization [4]
- Increased length of hospital stay[4] and days ALC [10, 11]
- Difficulties accessing Long-Term Care (LTC) and/or Rehabilitation Hospitals [11]
- Significant increase in direct costs of care [12]

Challenges in providing behaviour support exist across the health care system

The growing number of older adults with dementia has already started placing tremendous pressures on institutions, healthcare teams and families across hospital, long term care, and community settings. Over the last decade, the profile of residents in long term care has changed. Individuals with dementia are admitted to Long-Term Care Homes (LTCHs) later in their disease and have more complex medical comorbidities. Further, many homes in the province are physically set up for the profile of residents of former years - featuring three to four-person bedrooms similar to a hospital, shared washrooms and bathing facilities, crowded dining areas, and narrow hallways [13]. Health Quality Ontario has collected data on antipsychotic and restraint use as well as behavioural symptoms to inform new standards of care. The data suggest significant room for improvement in the care of persons with behaviours in the LTCH setting [14].

Regarding hospital pressures, a 2014 study found that the majority of patients in acute medicine units who were designated as ‘alternate level of care’ (ALC, meaning not requiring active medical treatment)

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[1] The term responsive behaviours will be used in this paper, however there are number of terms used through the literature and clinical practice to describe behavioural symptoms of dementia to include neuropsychiatric symptoms of dementia and behavioural and psychological symptoms of dementia (BPSD). Each of these terms recognize the behavioural and psychological symptoms of dementia that are influenced by biological and disease factors as well as unmet psychosocial or physical needs that cannot be clearly communicated, or that are associated with something in the environment that is confusing or frightening to the person (Gutmanis et al, 2015). It is also important to consider that while the majority of literature on responsive behaviours focuses on individuals with Alzheimer’s and Related Dementias, health care providers are increasingly involved in caring for people with responsive behaviours for individuals with a variety of diagnoses including but not limited to acquired brain injury, delirium, and substance use.

had a diagnosis of dementia and had been waiting over one year for long term care placement [11]. Another 2012 study that explored the causes of long-term delayed discharge inpatients in acute care settings found that mood, behavioural symptoms, and psychiatric conditions were present in 12% to 25% of alternate level of care (ALC) patients, and that 65% of ALC patients waiting for nursing home admission were prescribed psychotropic medications. As well, they found that ALC patients that exhibited physically aggressive behaviors had significantly more ALC bed days relative to the average [10]. A research study in progress at St. Michael's Hospital in Toronto suggests that prior to the implementation of a comprehensive education and quality improvement initiative, many health care providers struggled to work collaboratively to prevent, assess, and create individualized care plans for responsive behaviours due to the multiple, complex and competing demands of the acute care setting. The data from this ongoing study also suggest that responsive behaviours present a concern to patient and provider safety alike. These concerns are echoed by the experience of many OSOT members, who observe significant gaps in health care provider knowledge of dementia and in formal processes of care to prevent and respond to behaviours in acute care environments. This is problematic as there is evidence to suggest that persons with responsive behaviours have longer hospital stays, are more likely to require ongoing institutionalization and have poorer outcomes [10, 11].

With respect to the pressures faced by both families and providers in the community, while aging at home is a priority of both of policy makers and many Ontarians, many OSOT members endorse the observations of caregivers of persons with dementia when they report that there are multiple challenges to caring for a person with responsive behaviours in their home [15].

"Home care is confusing. It was hard to know what we qualified for and it was always someone different which was confusing for me and my dad. We got really tired of telling our story. We need information on changing needs as the disease progresses. Next, we need help for the caregiver as long as client is at home - everything from a night's sleep, going for groceries and meeting a friend for tea." [15]

Caregivers are often older adults themselves, and are tasked with the responsibility of caring for someone full time, while acting as a system navigator and care coordinator. Access to respite (in-home or in group situations such as adult day programs), assistance for personal care, tertiary/specialty seniors mental healthcare providers varies across the province and may or may not meet the needs of a person with responsive behaviours and their family or caregiver. Often caregivers of people with the most challenging behaviours are left to manage their care at home, with a maximum of 10 hours/week of CCAC care (which may vary by LHIN). They struggle to keep their loved ones safe day and night, while attempting to maintain their own physical and mental health, which often suffers as a result.

Policy context

Creation of Behavioural Supports Ontario

In 2010, in recognition of the need for system transformation to meet the needs of individuals with dementia who demonstrate responsive behaviours, leaders from the Muskoka Local Health Integration

Network (LHIN), Health Quality Ontario (HQO), the Alzheimer Society of Ontario, and the Ministry of Health and Long Term Care (MOHLTC) came together to build a holistic, system-wide approach to caring for people with dementia and who exhibit responsive behaviours. The model of care was designed to be person-centered, health promotion focused, and was based on information gathered from clinical expertise, best-available evidence and caregiver lived experience. In 2012 the Behavioural Supports Ontario (BSO) framework was piloted in four early-adopting LHINs and rolled out across the remaining 10 LHINs. The principles guiding the development of this model include: system coordination and integration, accountability and sustainability, person-centered care, behaviour as communication, diversity, collaborative care, and safety[16]. In recognition of ongoing need for specialty services to support the complex needs of older adults who demonstrate responsive behaviours across community, hospital and long term care, in the fall of 2016 the Ontario government announced an increased 10 million dollars per year of funding for the BSO program [17]. The BSO initiative was developed to integrate with and leverage existing programs and services for people living with dementia and who demonstrate responsive behaviours. There is significant variation in terms of how and where BSO teams have been rolled out across the province; some have been rolled into specialized geriatric services, geriatric mental health outreach teams, community support services, or long term care settings, and others have close partnerships with inpatient geriatric assessment units, memory clinics, adult day programs, and the Alzheimer Society[18]. At this time, no BSO funding has been used to create specific positions for occupational therapists; however, there are some OTs who hold both clinical and leadership positions within this initiative. In addition, there are OTs who hold positions on Geriatric Mental Health Outreach teams as general clinicians or case managers. Initial BSO documents identified an “expert practitioner” as a core member on Mobile Interdisciplinary Seniors Behavioural Support Outreach Teams (SBSOT) [19]; however the Ontario Society of Occupational Therapists (OSOT) is not aware of any OTs employed in this regard.

Health Quality Ontario Standards on Behavioural Symptoms of Dementia

In 2016 Health Quality Ontario reviewed the data relating to the care of persons with dementia and found there are significant gaps in care for persons with dementia and knowledge among service providers. There are significant variations in use of restraint and psychotropic use between LTCHs in Ontario, with an average of 23% of LTCH residents receiving an antipsychotic *without* a diagnosis of psychosis[14]. Given the risks associated with pharmacological management of behaviour, this is highly concerning. At the end of 2016, HQO released new, evidence informed standards of practice suggest an interprofessional approach to assessment and care planning, using both non-pharm and pharm interventions, careful monitoring, and supported transitions for patients with dementia[20].

Concerns about current management practices for responsive behaviours

There is a growing concern about the risks associated with pharmacological treatments for responsive behaviour including but not limited to:

- Stroke
- Sedation
- Parkinsonism leading to functional or mobility impairment

- Falls
- Death [21-25]

At the present time, antipsychotic medications are the leading response of health care teams in the management of responsive behaviours. In 2014, 39.0% of seniors in long-term care (LTC) facilities were prescribed at least one antipsychotic medication for management of behaviour [26]. Despite high levels of antipsychotic use, only 12.4% of LTC residents experience improvement in behavioural symptoms with pharmacological treatment[14]. There is growing evidence to state that pharmacological management of BPSD is minimally effective, and the evidence that is available is based exclusively on short-term trials. Expert consensus suggests that pharmacological management of behaviour is not indicated for most persons with dementia, and should only be considered after careful consideration, where the risk of the behaviours outweigh risk of psychotropic use, after individualized care plans are trialed, and then, only when carefully titrated, and for the shortest possible duration [20, 27]. This type of assessment and ongoing evaluation requires a careful, collaborative, and coordinated approach between members of the health care team.

> *"When I started as a nurse practitioner in LTC, I was shocked to see how many residents were receiving long term antipsychotic or benzodiazapines to manage behaviour. Staff really seem to struggle with creating individualized care plans amongst the complex, multiple competing demands of providing care in the LTC home." J. Nurse Practitioner in a LTCH*

There is increased acknowledgement and consensus for the need to use non-pharmacological strategies as the first-line treatment. In recognition of the risks associated with this line of treatment for individuals demonstrating responsive behaviours, there have been a number of practice improvement initiatives and guidelines rolled out in recent years for prescribing medications for the management of responsive behaviours [20, 27]. Findings of interest include:

- Reducing antipsychotic use may reduce all-cause mortality [28]
- Reduction of psychotropic use reduces falls and unnecessary Emergency Department (ED) Visits [12]
- An estimate that 25 million antipsychotic prescriptions could be avoided by 2021, and 448 million prescriptions by 2046 [12]
- A multi-year care strategy focused on team-based, data driven approach to managing behaviours could see a significant opportunity for cost savings across the health care system by 2021:
    - 19% ↓ in antipsychotic prescription costs
    - 8% ↓ ED visit and hospital costs [12]

Room for change:

Health Quality Ontario reports that of residents with behavioural symptoms in LTCHs, only 12.4% experience improvement in their symptoms. The proportion of people *without* improvement in

behavioural symptoms has not improved in the last four year [14]. Further, researchers from the respected Murray Alzheimer Research and Education Program centred at the University of Waterloo, Ontario suggest that traditional understandings of behaviour relied solely on a biomedical lens. When behaviours are understood as pathological, not only are caregivers' abilities to manage behaviour considerably limited, there are significant negative implications for the quality of life of those receiving care [29]. ***Novel approaches are clearly indicated.***

Occupational Therapist as Leaders in the care of Persons with Responsive Behaviours

Alignment of behavioural and occupational therapy practice models and standards

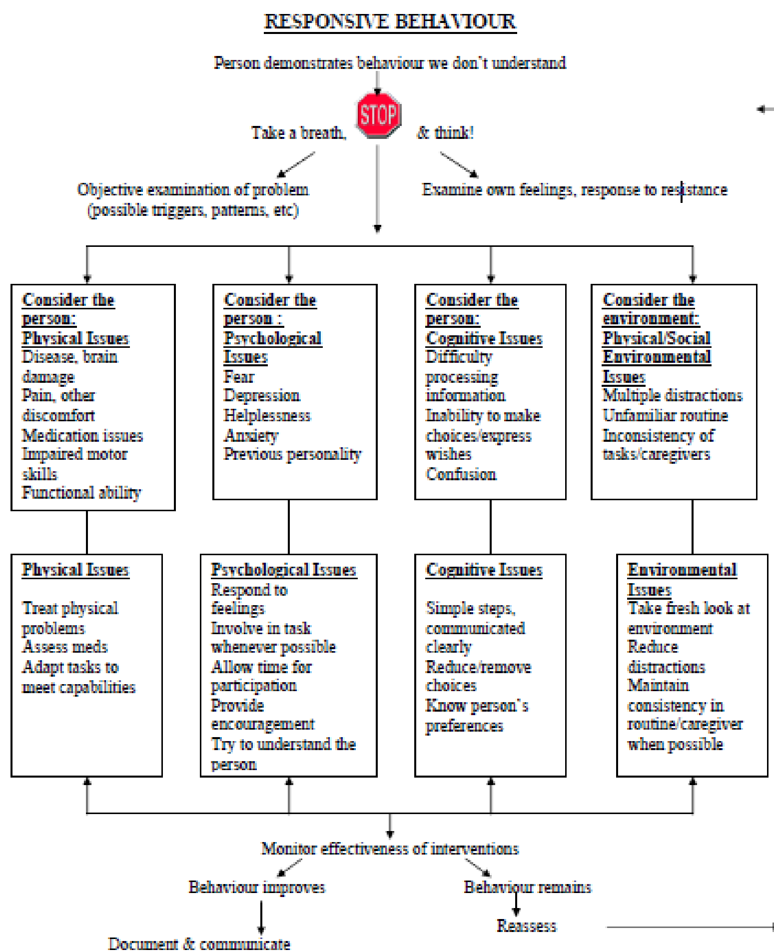
Occupational therapists (OTs) are trained to identify what matters most to their clients and to help them to overcome the barriers they face to engaging in their day-to-day lives in a way that is meaningful and health-promoting. OTs consider the fit between a person's physical, emotional, cognitive and spiritual health, the environment in which they live, and what it is they are striving to achieve[30]. For persons living with dementia, the confusion, fear and frustration that can result from a poor fit between what the person hopes to achieve, their abilities and their environment can be a significant contributor to responsive behaviour. The OT practice framework necessitates that interventions are rooted in the OT's assessment findings, and are monitored and modified as needed throughout implementation. Below, the theoretical and practice frameworks that underscore leading practice in behavioural assessment and non-pharmacological care planning are reviewed and the ways in which these align with practice models, skills and competences in occupational therapy are highlighted.

The dominant framework used by BSO clinical teams and other clinicians practising in a behavioural support capacity is the PIECES framework [31]. PIECES is an acronym which guides a holistic consideration of what may be contributing to or underlying an individual's presenting responsive behaviours – Physical, Intellectual (cognitive), Emotional, Capabilities (function), Environment, and Social/cultural – and which closely aligns with the occupational therapy theoretical model of P-E-O (Person-Environment-Occupation) [32]. The ABC (antecedent behaviour consequence) model, based in behavioural analysis, is also used as a model to guide assessment of responsive behaviours, particularly in terms of determining what may be "triggering" a behaviour [33]. The leading theoretical frameworks consider responsive behaviours to be a result of (1) an unmet need, and (2) a poor fit between the demands of the environment and the capabilities of the person.

What also must be considered when assessing the underlying cause(s) and possible triggers or antecedents for the responsive behaviour, is what function the behaviour serves for the individual. As occupational therapists, we may understand this as the "Occupation" in our PEO model, or the missing part of the PIECES model; what matters to this person, what are they aiming to achieve or what is their behaviour communicating about their needs? A 2012 Cochrane review has found promising evidence to support "Functional Analysis" based interventions for responsive behaviours [34]. This approach requires the clinician to systematically assess and strive to understand the meaning or function of the behaviour, and then use the information gathered through this process to guide the development of

hypothesis-driven, individually tailored strategies aimed to support both the individual with dementia as well as those caring for him. Findings from this review suggest that Functional-Analysis-based interventions can reduce the frequency of responsive behaviours and, through capacity building with caregivers, can improve caregivers' response to these behaviours. Due to constraints relating to scope of practice, defined role, and time, there are few professions that are able to lead the assessment, implementation and monitoring of non-pharmacological strategies in an evidence-informed and systematic way [35]. Occupational therapists have a depth and breadth of assessment skills that fill this gap [36]. It is worthy of note that while evidence-based interventions are growing in number, there is no universal, all-purpose intervention for treating this problem. Occupational therapists possess a variety of competencies to provide flexible, individualized, and comprehensive assessments in light of no one universally accepted framework for behavioural symptoms.

One such example of leveraging OT skills is a model proposed by Davidson [36], *The Behaviour Framework.* This presents a systematic approach that can be applied when dealing with any responsive behaviour.



Adapted from: "Dementia: A Systematic Approach to Understanding Behaviour", S. Davidson, in Geriatrics & Aging, 2007, 10(2), pp. 104-107

The evidence for OT-led assessment in a model such as above aligns and supports the recently released HQO standards for the care of patients with behavioural symptoms of Dementia in Hospital and Long-Term Care settings [20]:

1.) Comprehensive Assessment
2.) Individualized Care Plans
3.) Individualized non-pharmacological interventions
4.) Indications for Psychotropic use*
5.) Monitoring and Titrating Psychotropic use*
6.) Switching Psychotropic Medication*
7.) Medication Review for Dosage Reduction*
8.) Mechanical restraint
9.) Informed Consent
10.) Specialized Interprofessional care team
11.) Provider Training and Education
12.) Caregiver training and Education
13.) Appropriate Care environment
14.) Transitions in care

*Although OTs are not involved directly in prescribing, they provide essential assessment and reasoning skills to help guide health care team discussions about risks and benefits as well as alternatives to psychotropic use.

Occupational therapists use a practice process that involves considering the social, practice context and the unique individual. As part of the comprehensive practice process OTs complete a comprehensive assessment, work collaboratively with stakeholders (the client, other care providers, family) to agree upon goals and priorities, then implement a plan while continually monitoring the progress against the expected outcomes and goals, and lastly using outcome measures to measure success [30].

Improvements in the care of persons with responsive behaviours will require a variety of skills and coordinated efforts. Occupational therapists are trained to use a variety of enablement skills to engage clients, families and other care providers including collaboration, consultation, coaching, advocacy, education[30]. These skills and professional values align closely with those of the BSO strategy and guiding frameworks, to include system coordination and management; integrated service delivery (intersectoral and interdisciplinary); knowledgeable care team and capacity building [16].

OT role and leadership in behavioural management

There are calls to maximize and expand scopes of practice of all health professionals to improve the sustainability, efficiency and quality of health care provision. Where all health care providers are practicing to their full extent of their knowledge and skill, client care is optimized [37]. Effective behaviour management strategies require astute assessment skills using a broad, multidimentional lens [29, 35]. There is good evidence to suggest that OTs have the necessary foundational knowledge, skill and judgement to fill this role.

"Our GMHOP clinician (who is an OT) helps us balance decisions about safety and risk when managing responsive behaviours and to provide us with novel strategies and approaches that expand our abilities to use non-pharmacological interventions. She brings a perspective and expertise not only in behaviours,

but in the care of people with significant mental health or trauma issues that our team does not have."
~ C. RN and Director of Care in a Long Term Care Home

Consider OTs in quite different practice settings and how each OT makes unique and vital contributions to advancing the care of persons with responsive behaviours:

- Joanne is an occupational therapist working in a LTC home. She is exceptionally skilled in providing seating and mobility devices, such as custom wheelchairs for clients. She assesses a person's physical and cognitive status as well as the demands of the environment. She has made very astute observations about residents' pain, positioning, pressure relief, ADL (ie. transfer, toileting and feeding), and functional mobility needs and implemented strategies to manage these issues, which have thereby reduced behavioural displays in persons with dementia.

- Elizabeth is an OT working on an Acute Medicine unit at a teaching hospital. She frequently receives referrals for inpatients who demonstrate behaviours that interfere with activities of daily living such as bathing, dressing, and dining, as well as seating concerns. Her skill set in assessment of the person and environment factors that interfere with the patient's abilities to engage in basic daily activities enables her to effectively identify and come up with creative strategies to address these barriers and maximize the patients' function and participation. Elizabeth has found that by promoting autonomy and engagement in basic daily activities, behaviours can be significantly reduced.

- Allison is an OT on a Trauma and Neurosurgery Unit at a Tertiary Hospital. She provided leadership and education for an initiative for a person-centered care approach to manage responsive behaviours in a busy, acute care setting. She recognized that patients who demonstrated behaviours required costly constant-care observers and were delayed in discharge and accessing rehabilitation. She identified a need for individualized care plans and team communication about the care plan. She leads weekly team rounds to implement, monitor and adapt the care plans as needed to help reduce behaviours in a more timely manner

- Sarah is an OT working in the community with specialized geriatric mental health services. She provides practical suggestions to informal and formal caregivers on how to maximize a person with dementia's ability to remain independent in their home and at the adult day program, minimizing their responsive behaviours and reducing caregiver stress. She identifies and initiates future planning, identifying when community resources have been exhausted and long term care placement application is appropriate. When the person moves to long term care, she provides information on strategies that work in the person's home to facilitate their transition into long term care.

With respect to treatment, OTs are well positioned to be experts in non-pharmacological interventions, as engaging people in purposeful activity is inherently non-pharmacological[36]. OTs have a rich education and experience in working with a variety of treatments to enhance quality of life of both

caregivers and people with Dementia[38], and have been acknowledged as a key partner in the care of people with Dementia (Mental Health Commission of Canada document). Interventions such as person-centered care [39], tailored behavioural plans [40], activity therapy [41], Montessori Methods for Dementia[42, 43], multi-sensory therapy and aromatherapy [34] are some of the interventions OTs may use to help a person with responsive behaviours.

There is a growing body of evidence and care standards that make the contributions of an occupational therapist essential to the management of behaviours [HQO]. Some of the leading interventions that are emerging in the literature align closely with OT practice, competence and enablement skills. There is high level evidence to support the following interventions:

- A study of community-dwelling individuals with dementia found the use of **individually-tailored activities based on an OT assessment in and intervention** can caregiver burden, preserve daily living and cognitive function and defer placement LTC[44]
- The use of **personalized pleasant activities -** either with or without social interaction- reduce agitation[45]
- **Experiencing pleasure is a skill that can be maintained through positive engagement in activity.** The ability to experience pleasure and positive interactions preserves not only a person's functional capacity, but also their ability to accept care without behaviours [46]
- **Environmental modifications can reduce behavioural displays** [47, 48]. OTs are experts in modifying environments to meet individual needs.

Occupational therapists in both general practice roles with older adults as well as in more specialized clinical roles focusing on behavioural assessment have an important role to play in supporting the management of responsive behaviours across practice settings.

Conclusion:

The pressures that are facing our healthcare system at this moment and time and which are expected to grow with the *rising tide* of Ontario's aging population require a multifaceted, collaborative, interprofessional approach to system transformation. Responsive behaviours are present in up to 96% of people with dementia and can have a significant impact on quality of life, health outcomes, eligibility for long term care, length of hospital stay, and caregiver health. With growing evidence that pharmacological treatments are not a catch-all solution to this problem, important initiatives such as Behavioural Supports Ontario (BSO) and the new Health Quality Ontario (HQO) standards are helping to pave the way for a new approach to understanding and working collaboratively to manage behavioural symptoms in our patients, clients and residents with dementia.

When we review the current, leading approaches to behavioural assessment and treatment, it is apparent that occupational therapists possess a unique and invaluable lens through which responsive behaviours can be understood, interpreted and managed. Our practice process and leading practice

models align seamlessly with leading behavioural approaches and guide us through a holistic assessment process to understand the meaning or function behind the behaviour and consideration of the combination of cognitive, physical, emotional, spiritual, environmental and function-related factors impeding a person from living meaningfully and fully. Occupational therapists possess key assessment, enablement, treatment, and evaluation skills that align with current best practices with this population. Our strong skills in interprofessional collaboration and leadership position us to be leaders in this unique practice area.

As our health care system looks to develop new and innovative ways to manage the growing number of people with dementia, many of whom will demonstrate behaviours that pose a barrier to the safe delivery of care and prevent safe and smooth transitions across the continuum of care, we advocate for occupational therapists to be recognized and supported for the important role they can play in both leadership and clinical roles to advance system transformation, reduce the health care costs related to consequences of responsive behaviours (falls, ER admissions, staff turnover, etc.), and, most importantly, enrich the quality of life of residents of Ontario long-term care homes for as long as possible.

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