Summary of Results from Survey of Allied Health Workforce in Residential Aged Care (October 2023)

Overall, this year's survey found similar trends to last year's, though it should be noted that the composition of respondents was slightly different, with a greater proportion of respondents being occupational therapists and a lower proportion of respondents being speech pathologists, compared to 2022.[1]

Any changes commented on by respondents to this year's survey most directly relate to the impact of the commencement of AN-ACC on 1 October 2022.

Changes to allied health roles

56% of respondents said their role had changed since introduction of the AN-ACC. Of those respondents, 18% had lost their role, 19% had been redeployed, 48% had their hours decreased, and 25% had increased referrals.

> 'My hours reduced from 38 to 7.5 hours per week.'
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> 'My hours have reduced by half and referrals have gone up from 40 per month to 50 per month.'
>
> 'I am no longer allowed to treat residents as they are not directly funded for ongoing treatments. . .They just want me to do the assessments and design the care plans that no one will care to deliver. From a full-time contract for a 60-bed facility, I am now just doing 15 hours a week.'
>
> 'We had 11 nursing homes a year ago. We have 1 now and it's under threat also. We never get aged care referrals. We had 34 employees, 27 were physiotherapist and OTs. We now have 7, 3 Physio and one part time OT.'
>
> 'Residents must pay privately for most services.'

Changes to clinical team structure

Clinical team structure had changed for 50%. 90% of these respondents had seen the number of allied health professionals (AHPs) decrease and 34% saw the number of allied health assistants (AHAs) decrease.

> 'AHA role no longer exists, existing AHA switched over to PCW [personal care worker]. PT role is totally dependent on non-clinical head office decisions. OT services no longer available, residents have to pay for assessments/reviews.'
>
> 'Our allied health team hours got reduced significantly across multiple sites and I can see the compromise on resident allied health professional (AHP) services. And increased stress and burnout within our team (reduced hours less therapist and less support, but with the same amount of referral numbers and expectation from clinical team/ resident family on AHP services).'

[1] In the 2023 survey the six most represented professions (N = 218) from greatest to least were: occupational therapy (34%), physiotherapy (26%), music therapy (13%), podiatry and speech pathology (7% each) and exercise physiology (5%). In 2022 (N= 279) they were speech pathology (27%), physiotherapy (23%), occupational therapy (22%), dietetics (7%), osteopathy (6%) and social work (5%).

Changes to services provided

For 54% of respondents, the services provided by their profession had changed. For 61% of those respondents, services had decreased, for 48% available services had deteriorated, and for 72% the number of individual treatment sessions had decreased.

> 'Residents are no longer receiving any mobility training, post hospital rehabilitation, functional training and pain management interventions. Our group exercises classes are scrapped. Most residents and their family members cannot afford private physiotherapy interventions.'
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> 'Private therapy arrangements with residents has increased.'
>
> 'Individual therapy is mostly self-funded.'
>
> '. . . Many RACFs don't prioritise allied health unless they are directly funded to do this. Unfortunately the removal of the Pain Management Program (which was necessary) has resulted in a loss of allied health staff from facilities. This should have been replaced with high value evidenced-based care to help maintain independence, strength and function and manage falls risk.'

Inappropriate/unsafe delivery of services

32% of respondents were aware of instances where allied health assistants (AHAs) were assigned roles/duties when those roles/duties should have been undertaken by allied health professionals, or where the AHA was not adequately supervised. (Note: this was a new question in 2023.)

> 'AHAs completing assessments that should be undertaken by the therapist. Supplying equipment without therapist assessment and increasing scope without additional training.'
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> 'Lifestyle coordinators and AHAs are delivering clinically inappropriate exercise programs.'
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> 'Residents admitted from hospital to RACF with complex care needs needing 1-1 physio dumped into groups with non-trained staff to do exercises that are non-specific.'
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> 'AHAs are completing more of the individual therapy sessions.'
>
> 'Equipment prescription.'
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> 'Supervision of allied health assistants being completed by nursing staff.'
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> 'Hours of treatment and pain management completed by physios previously was 32hrs per week. Then immediately the day of AN-ACC starting, they miraculously weren't needed anymore, with Physio treatment and pain management dropping to 3hrs per week only. . .and apparently now the employed Physio aid can 'do all the work the Physio did' (the centre's actual words in writing).'
>
> 'Music or art 'activities' in some units not being facilitated by qualified therapists largely due to budget.'
>
> 'AHA trained in foot care (2 day course) allowed to treat 'low risk' patients.'
>
> 'Myself being employed as a Physio Assistant I am constantly completing tasks which a Physiotherapist and/or Exercise Physiologist should be doing. These tasks include Manual Handling training, Falls assessments, Exercise Programming, completing new resident assessments, Mobility Reviews.'

Inappropriate substitution of non-allied health workers

32% of respondents knew of instances where personnel from outside allied health were inappropriately assigned allied health clinical roles/duties. (Note: this was a new question in 2023.)

> 'Physio groups and exercises have been given to lifestyle staff to do. This takes away the understanding of a lifestyle team which is to support individuals to engage in meaningful activities and purposeful occupations.

Whilst lifestyle can work on individual physical mobility goals and group programs it is not their role to do the job of a physio. Their role is to look holistically at a person and provide interventions to help that person live their best life. With the cut to physio services organisations have tried to make it up with inappropriate ways with people who are not skilled to do the work or their resources and skills can be used elsewhere (I am an OT that manages a lifestyle team).'

'Carers and lifestyle staff have been asked to walk residents. However, given their busy schedule, they do not walk residents and this is how residents lose their mobility. There was an incident that a resident had a fall while walking with a carer, who was not aware of a specific gait pattern of a Hemiplegic client.'

'Unqualified musicians asked to take on roles that require a Registered Music Therapist.'

'Lifestyle staff are asked to do rehabilitation after fractures. Facilities are not funding for physio services.'

'Activities person doing assessments and counselling, was previously done by the social worker.'

'RNs doing post fall reviews and all components that previously were completed by physios.'

'My site are currently undergoing these changes. My hours will be gone in 2 weeks from my normal site. AHP have been asked to train the RNs how to use the TENS machine and heat packs.'

'Equipment prescription has lots of overlapping scope, but is a significant challenge especially when OT on leave. Manual handling also has overlapping scope, but again sling prescription, technique, etc ongoing challenge for complex residents. Care and nursing staff may not be aware of risks.'

Workforce outcomes

38% of respondents said they didn't intend to keep working in residential aged care.

The themes described above, together with those detailed in 'Further comments' below, all contribute to allied health professionals' decisions to discontinue their work.

However, most strikingly, 82% of respondents said they were concerned about the future of allied health in RAC, and about the future safety or quality of care for residents.

Quality and safety of care

'I would love to continue to work in aged care however the role of OT is no longer valued. We can help so much!'

'I would not like to work in an environment where my professional service is just a tick-box activity without real benefits for the consumers.'

'I have come to appreciate providing treatment to aged care and wish to continue doing so but not in an aged care facility. It has now mainly become business focused, not resident focused. Staff are burnt out and residents are often neglected.'

'I feel bad for not really giving the best service for the residents because of the reduced time and reduced number of allied health. I feel bad for half of the residents being removed from the list for Physio service.'

I previously worked in Aged care assessment. . .I am unlikely to work clinically in this capacity again despite being very passionate about this work. Over many years I have delivered high quality outcomes to clients but was only able to do this by working many many hours of unpaid overtime. This has been to the detriment of myself and my own health. . .the things that I see in aged care in Australia run counter to my values and. . .I am burnt out. . .'

'. . .it doesn't feel like safe practice and I'm not comfortable with it.'

‘No care for elderly residents. No one is providing rehabilitation to them. They lie in bed after fracture, with no further rehab and they lose mobility for ever. . .We used to do lots of mobility trainings with them, now many of our residents have lost their mobility for good and now in bed / chair bound. Most residents are now taking more pain medication as effective pain management from physiotherapist is now taken away from them.’

‘The physical and mental health of residents have suffered. If more variety of allied health is not included in care, residents’ quality of life will further decline.’

‘Not all sites have enough staff including personal caregivers registered nurses and AHPs to complete good gold standard care. AHPs can’t recommend the correct options if the staff and resources aren’t available. We often have to compromise to use what we do have to provide the best/safest options for our residents even if we know it’s not ideal. AHP have no mandate over care minutes so management often don’t allocate enough resources and functional hours for me to address the referrals and care needs of the residents.’

‘I will be able to find jobs in any area. . .so please do not think that I am writing this for my personal gain. I am doing this as I am deeply concerned for our people in aged care. How could Australia be proud of what they are doing? My heart goes out to the 'humans' in aged care homes.’

‘Reduced quality of life outside of trying to meet all personal care needs - reduced allied health hours means less time for 1:1 interaction and reduced opportunities for engagement in meaningful activities.’

‘AN-ACC as a system I believe is much better than ACFI however how aged care providers are implementing it are the concerns I have. Using it as an opportunity to reduce allied health hours rather than supporting residents to have choice and sufficient time with allied health to achieve their goals and maintain their level of function.’

‘The care minutes is a big focus in aged care. It concerns me Allied Health are not factored into this.’

‘There really should be mandatory allied health hours funded. Residents are being expected to pay for additional private therapy, in low socioeconomic areas, some residents are missing out. I’m concerned about the future of allied health in aged care, many staff have left and will not return.’

‘Speech pathologist role in aged care as it stands is limited to swallowing assessment and occasional opportunities for education. We do not get funded to offer any preventative work or communication to individual or in a group setting. We only get to do 1/2 of our jobs.’

‘There really should be mandatory allied health hours funded. Residents are being expected to pay for additional private therapy, in low socioeconomic areas, some residents are missing out.’

‘The limited scope of which allied health can be 'allowed' to practice is the primary workforce retention issue. People get bored and have low job satisfaction but also burnt out from being unable to provide what they know will help residents. Ultimately, this results in residents being denied opportunity to receive restorative and enabling care interventions that promote independence and purpose [but] rather defaults to a care culture of compensatory services.’

‘Without mandating care minutes for allied health, I am concerned there is a significant risk for the future of allied health and subsequent quality of care provided to consumers. While I strongly agree with increasing RN care minutes, the lack of recognition for other members of the multidisciplinary team risks an overly clinical focus and a move away from holistic and person centered care. RNs alone do not have the skill set to appropriately manage the plethora of complex residents’ needs. Linking funding and RN care minutes leaves providers with little option but to reduce allied health to remain financially viable.’

‘As AH staff at RACFs, we seem to be at the mercy of whatever funding model has been implemented and this significantly determines what treatments are allowed, the hours and how many staff are employed. It should really be the other way around – what is clinically justified and in the best interests of each resident.’

‘There is nothing to hold organisations accountable to implementing the standards on a daily basis, and poor education around the need for suitably qualified allied health care professionals to do the right work.’

‘Allied health should be care minuted, not included under National Quality Indicator Program as the government is proposing. They also should not use Allied Health concepts in the new quality standards without recognising the crucial role Allied Health plays in those ie reablement.’

Further comments

76% of respondents said there had been no improvements to outcomes for residents since AN-ACC.

‘Previously I felt we caught people before they fell’

Below is just a sample of the many comments from survey respondents about the negative outcomes for residents related to allied health.

‘Overall clinical care has reduced drastically. Residents' therapy times were taken away from them without their consent. We have seen more falls, more pressure injuries, more fall related hospitalisation / ambulance call outs, more GP reviews for pain medications. Overall less healthier lifestyle and more residents are forced to remain bedbound / chair bound. . .’

‘Residents are no longer receiving the adequate allied health services they need to maintain their function and mobility or manage their pain.’

‘AN-ACC while on the surface enables provides to provide a greater range and frequency of allied health services; in implementation I have experienced a significant decline in services.’

‘Residents are given pain meds and falling over. No exercise interventions for residents. Their therapy was taken away without asking them.’

‘In terms of their care it is the same as it was before. In terms of their Allied Health support, it is worse that it was before, less availability and less time afforded to residents for reablement and pain management, less time for connection.’

‘Less time with functional treatment, so most residents are now less active, sit more, have more pressure sores, functional decline is now putting more pressure on nursing staff as well. Allowing the centres to decide their funding spend has NOT been to the help of any resident.’

‘At the commencement of AN-ACC, the allied health programs had improved from the previous pain management model, however it seems that recent changes will not see much improvement for residents' health and wellbeing due to significant reduction in allied health services in RACFs.’

‘I have seen no improvements at all. I am not saying this out of anger or frustration but out of deep concern for aged care residents.’

‘A resident loved to go for a walk x daily, 5 days with AH and weekends with family/self. No falls during that period. Once walks stopped, 4-5 falls since, now being wheelchaired beyond the bedroom.’

‘Far far worse outcomes. 71 yr old butcher Parkinson’s now multiple falls couldn’t stand at one home no physiotherapist at least six months possibly year. I saw for free 4x now a month later walking but still falling. Family have to pay for me to keep coming after I see under care plan and that runs out.’

‘I only get to see a resident individually once or twice a week, not for that long and only for 8 weeks then they have to go back on the waitlist. We are capped at seeing maximum 60 percent of the nursing home residents as that’s all they will pay for. When I was doing pain management I could see as many of the residents as possible almost, and see them 4 times a week for total 80 mins. It was a lot of time to help someone. Sure it was pain management supposed to be massage etc but I did try to improve their pain in ways like activity and exercise and mobility and did anything I could to help them with my 80 mins. Now I feel like I don’t help anyone.’

‘Residents have had more falls, increase pain and less interaction with Physios. Rapport to some residents has been affected as well. During assessment, they tend to not trust me because I do not see them anymore or because they forgot about me. Seems like they just met me the first time.’

‘On the whole I have seen little change to RACF’s catering and kitchen staff’s knowledge of texture modified foods improve and/or take on feedback from speech pathologists.’

‘Clinical risk increasing as no capacity to train staff due to reduced hours leading to long lead times when risk is identified. Nurses leaving staff in bed because they are too scared to assess mobility post fracture. Poor manual handling practices as PTs cannot monitor with current hours. Lack of allied health input into areas of clinical risk means it is reactive (once a PI exists or falls occur) rather than proactive.’

‘Changes are still new so unsure how it will look in the long term, but I can see that management feel there are many small roles that I take on as a social worker that they feel the clinical or care staff will need to take over. For example providing emotional support and engaging social supports for residents, providing practical supports engaging with service providers. My role as a social worker is becoming more about the marketable pieces of work (QCAT, Public Trust/Public Guardian etc) and less about the wellbeing of residents (emotional support, having time to talk and check in, less time for connection – which is linked to loneliness and isolation, less time to feel heard).’

‘I am a passionate OT, who enjoyed working with elderly people in aged care facilities. After AN-ACC reforms, it brings too much negative impacts to the residential aged care residents as well as to the quality of PT/OT services, we are overworked and unable to maintain same services and definitely reduced the time to see each individual residents. And unfortunately, I am one of the therapists that eventually make the decision to work in another field rather than just being in aged care due to too much pressure at work, and due to losing the enthusiastic for work. . .Hope the government can really understand the real situation in the aged care industry, and adjust or refine the funding model to make the residents’ services better as well as to improve the work environment for Allied Health professionals in aged care!’

‘Severely impacted provision of occupational therapy service - no guidelines on what occupational therapists can do, no guidance on equipment prescription, behaviour management etc. and also not clear on what equipment is funded for aged care facilities.’

‘I am disappointed that there has been a significant reduction in allied health services in RAC. The RACFs do not seem to understand the importance of allied health services to support their residents' health and wellbeing and quality of life.’

‘Used to work in XX facility for pain management. Can do sub-acute rehab eg walking, electric wheelchair manoeuvre. XX facility stops pain management. Now shifted to work in YY facility. Some residents there have rehab potential. However we were told not to do rehab. Residents can only choose to get private allied health service. YY cut down the hours of Allied Health service after AN-ACC introduced.’

‘I think there is more scope for us to appropriately treat the residents we do see as we aren't restricted by the pain therapy role we had in ACFI. However, we are more limited in how many residents we are able to see and how long we are able to see them for.’

‘Pain management is inherent to ensure residents’ quality of life [is] optimised. Since the introduction of AN-ACC, pain management and other programmes aimed to increase and maintain a resident’s functional ability have ceased. Clinical staff report that pain is affecting all aspects of Activities of Daily Living and they have observed an increase in behaviours that cannot be deescalated using non-pharmaceutical interventions.’

‘Hours of occupational therapy services in aged care is largely reduced or has become nil in most facilities.’

‘. . .If one agrees that a person living with dementia must be recognised as a person with thoughts, dreams, wishes, purpose and emotions there is a need for OTs to be working in this space to make this happen.’

‘As an OT providing specialist mental health in-reach services into RACFs, I have not seen any change to the 'on the ground' role and scope of any allied health profession. . .There are regular observations of missed opportunities for RACFs to utilise OT to the full breadth of scope of practice to assess and inform care and functional supports for people in aged care from both physical and cognitive decline perspectives. The Lifestyle programs can greatly benefit from OT oversight and input to maximise participation and adapt to the various levels of abilities in RACFs. Most frustratingly, Speech Pathologists are only ever used for swallowing/dysphagia assessment. I routinely see missed opportunity and repeated inability to engage with Speech Pathologists under the model for communication assessment and interventions. This has led to many residents becoming suicidal and 'locked in' but also contributing to the reported agitation and aggression where communication is a barrier. The role of Social Worker and Psychologist is grossly absent in RACFs as being in an RACF is a significant life stage change and psychological distress associated with grief and loss. Dietetics and the planning and preparation of nutritious and appetising foods remains at a very poor level with an over reliance on nutritional supplementation. Nothing has changed.’

‘We went from 2.5 roles at one home down to 1.25. After 6months when I returned to the home I had been made redundant from the MDT were surprised that they had more residents falling and functionally declining as they did not appear to realise the impact of our AHP role within the facility. Having halved the workforce (our company had 800+ now about 400) it also means there is less time to do the small jobs such as maintaining equipment or touching base and seeing how their residents are each and every morning as we used to, or spend more time on informal observations, and worryingly we no longer have access to the incidents/falls register. So, instead of catching the patterns and or recommending strategies we only tend to review those falls where there has been a serious accident or someone is falling so often the HOD feel it is worth our input, which is disheartening as previously I felt we were a valued part of the solution and caught people before they fell.’

‘Very sad - role is now about completing annual assessments rather than providing high value care.’

‘My hope would be to have a specific allocated funding for allied health in aged care to secure our service to help the residents maximise their functions and prevent complications.’

‘We can’t rely on RACF to choose to fund allied health services. This needs to be either mandated OR funded separately. This limits the ability of the residents to access services and takes away a resident’s choice and control about the services they receive. The facility makes decisions about whether they “value” allied health staff enough to include them in their care teams. They often make decisions about this without understanding the evidence for and benefits of certain treatment for their residents.’

'People's experiences and opinions around the AN-ACC change would be heavily influenced by the provider they are working for, and whether they value allied health in this setting’

There were also respondents who saw some positive changes since AN-ACC. This often related to the replacement of the ACFI funding model, and in some instances also suggests that at least a few RACFs are providing allied health care towards the ‘best practice’ end of the spectrum. It then becomes important to investigate what distinguishes these facilities and providers from the majority referred to in the more negative comments above.

‘Transitioning to the AN-ACC funding model has allowed us to provide input to our residents which is solely based on clinical need, we are no longer impacted by funding KPIs. It has been an extremely positive change for all staff as we have implemented further exercise groups and have more flexibility in how we utilise our hours onsite. The overall Allied Health hours has reduced as a result, but our approach has been more focused and centred around our physio scope of practice.’

‘It's been great to have the focus shift from purely pain management to a broader scope of OT practice.’

‘While my experiences with the change have been very positive, I am aware of other providers who have had a less proactive approach. I am also aware of others AHPs who have been made redundant as a result of the changes. People's experiences and opinions around the AN-ACC change would be heavily influenced by the provider they are working for, and whether they value Allied Health in this setting. I have been told that Allied Health input is still expected and funded under the AN-ACC, but it does not seem to be valued as highly for providers who place a strong emphasis on funding.’

‘Residents are seen purely because it is their clinical need, hence we can spend our time on more active input and reablement, as opposed to passive strategies in the ACFI. One example would be helping a resident regain her mobility after a hospital admission because we had the flexibility to use our hours for more intensive rehab over a period of time instead of being bogged down with compliance for 4as/4bs.’

‘Residents getting exercise as therapy from PT a few times a week focusing on strength and balance instead of providing unnecessary pain treatments.’

‘Rehab of one resident to walking possible because Allied Health weren’t too busy with ACFI 4b claims. PT can use full scope of modalities - OT able to use different cognitive assessments instead of just PAS. Additional information for adapting activities from increased assessment choices.’

‘Resident had not showered for over 6 months, OT was able to work 1:1 to complete activity analysis and work on strategies for engagement. Resident now regularly showers. Resident had not left their bedroom for 1year +, OT was able to engage resident in group activities promoting social engagement.’