Aged Care Royal Commission Impact of COVID-19 on Aged Care supplementary submission

Submission by the
Australian Physiotherapy Association

August 2020

Authorised by:

Phil Calvert
National President
Australian Physiotherapy Association
Level 1, 1175 Toorak Rd
Camberwell VIC 3124
Phone: (03) 9092 0888
Fax: (03) 9092 0899
www.australian.physio

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

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Executive Summary

The Australian Physiotherapy Association (APA) welcomes this opportunity to make a supplementary submission to the Royal Commission into Aged Care Quality and Safety investigation into the impact of COVID-19 on aged care.

While the effects on individual workplaces and their residents/patients/clients vary because of local infection rates and responses, it is clear that there are some universals impacts of COVID-19 on the workforce across all aged care settings:

- stress, anxiety and fatigue caused by continually changing workplace requirements
- heightened sense of responsibility and vigilance about infection control
- additional responsibilities resulting from increased staff sick leave as staff test for the virus and isolate; and reduced family/social support for older people
- being stood down and loss of work hours
- fear of infection and infecting others
- lack of PPE and confusion about its use.

For older people, the impact has been severe and, in many cases irreversible, including:

- Mental health and cognitive deterioration contributed to by factors such as isolation, quarantine, reduced physical activity and lack of family/social support.
- Increased falls and pressure injuries
- Deterioration in those living with dementia.

Residential aged care residents have endured many severe restrictions, including:

- receiving less support due to care staff focusing on infection control; understaffing and family/friends lockouts
- being confined to their rooms for weeks
- not receiving physiotherapy treatment due to lockdowns and understaffing.

While many of the workplace issues settled following the first wave of COVID 19, the second wave sweeping Victoria and NSW hotspots highlights the need to address these issues.

We consulted extensively in the development of this submission, including:

- surveying our members working across the aged care sector – in residential aged care facilities (RACFs), hospitals and providing home care – to understand how the pandemic has affected the workforce and older people
- conducting interviews with healthcare provider companies and physiotherapists managing admissions and wards in hospital settings
- consulting with other allied health profession associations to understand the broad impact on provision of allied health services and its workforce.

The physiotherapy profession is aware of the long-term COVD-19 rehabilitation and recovery challenges we will face and must prepare for.

We propose solutions to both short-term and long-term health impacts affecting our older people.

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Summary of Recommendations

Recommendation 1

Amend ACFI provisions to align with evidence-based interventions, particularly exercise provision.

Recommendation 2

Rehabilitation and COVID recovery: invest in COVID-19 rehabilitation in the community with a dedicated MBS-funded Recovery Card. Acting in the same way as a Veteran's Gold Card; the COVID-19 Recovery Card would entitle those affected by the virus to access the consumer-driven, evidence-based interventions.

Recommendation 3

Urgent provision of iPads and additional staff resources to supervise their use in RACFs to enable care provision via telehealth and engagement with families and friends, particularly in COVID hotspot areas.

Recommendation 4

Establish a multidisciplinary Aged Care COVID-19 Response Team to conduct daily telehealth (phone) welfare checks on older people in the community to ensure they are receiving the health care they require.

Recommendation 5

Introduce a two-tiered funding model that funds the ongoing, independently assessed care needs of older people, supplemented with a substantial additional layer of allied health funding for restorative and reablement care.

Introduction

At the onset of and during the first wave of COVID-19 from March to mid-May 2020, much of the aged care sector was in disarray.

Residential aged care facilities (RACFs) locked external (privately funded) physiotherapists and other allied health practitioners out. Large healthcare providers (who provide almost 100% of residential aged care physiotherapists and many other allied health staff) and their employees scrambled to adapt to new rules restricting physiotherapists and other allied health practitioners to working at one site only in a bid to reduce transmission.

Provision of Personal Protective Equipment (PPE) was poor and inconsistent for a number of reasons – a lack of availability, mixed messaging about the efficacy of mask wearing, no clear requirement to provide it and what some staff perceived to be a reluctance by aged care providers to supply more than mandatory necessities.

In the home care sector, fearful clients cancelled 50 per cent of appointments, affecting allied health practitioners employment and their clients' care.

Further, some healthcare providers moved to safeguard clients and employees by ceasing all face-to-face appointments.

Telehealth service delivery – while a successful mechanism in the broader community – did not have great take up in the aged sector in large part due to a lack of education about its use and efficacy within the sector. An investment of time and resources was also required to set it up for many older people, many of whom were not be tech literate, and to supervise video consultations.

The localised approach reflecting COVID-19 transmission has resulted in inconsistent approaches to PPE provision and use, and confusion about requirements.

Clear sector leadership and government direction is key to addressing these issues.

The May 2020 introduction of the Visitation Access Code in residential aged care marked a shift in the sector. The mandating of mask wearing in some hotspots (July 2020) gave clarity in those areas and helped reduce the high levels of anxiety among staff and older people and their families.

From May to July 2020, many parts of the sector appeared to settle down to a new way of operating. New routines emerged and COVID-19 transmission became less of a threat in many parts of Australia.

Older people in the community realised the importance of ongoing care as their mobility and function declined. Healthcare providers report that in-home appointments resumed in numbers exceeding pre-COVID levels as consumers tried to make up for lost time or address new health concerns that had arisen during social isolation.

Across Australia, the provision of PPE improved as required in specific localities.

Restricting physiotherapists and other allied health practitioners to one site continues to have vast flow-on impacts to staffing levels and care giving. The strains on the workforce remain

and continue to grow. Healthcare providers report extraordinary administrative burden of managing staff sick leave as COVID testing and isolating requirements reduce staffing resources across the sector. This also remains an issue for the staff themselves and for the ongoing care of older people.

Hospital-based physiotherapists report grossly inadequate transfers and handovers of COVID-positive aged care residents to hospitals – with many arriving without identification and care plans, and unable to communicate with hospital staff.

Older people across residential aged care continue to deteriorate, especially those living with dementia.

Long periods of confinement to their rooms, reduced staffing levels and restricted social supports are resulting in clear decline in mental health, cognitive and physical function.

The care of those living with dementia, who require exercise as part of their now-disrupted routines, has all but ceased in residential aged care and hospitals in many cases.

A lack of exercise and movement – across all areas of the aged care sector – has put older people at risk of life-threatening falls. There is now increasing evidence of increasing numbers of falls presentations to hospitals – and this is just an indicator of what is to come.

The second wave of COVID-19 in Victoria and other local hotspots has amplified the issues experienced earlier this year. Panic and fear has spread has spread throughout the understaffed sector and among a highly vulnerable demographic.

A sense that allied health care was not essential is slowly changing with a growing awareness of its importance in maintaining mental, physical and cognitive function.

The current archaic funding model denies access to any form of physiotherapy treatment to a quarter of the older people in RACF. Its narrow focus does not support the delivery of full, patient-centred care and does not enable flexibility to treat urgent and emerging issues.

COVID-19 has demonstrated that the time must be up for restrictive models of care that deny older people access to and choice of treatment.

Physiotherapy is vital in the treatment of these emerging health concerns and in COVID-19 recovery and rehabilitation.

The profession has led COVID-19 cardio-respiratory ICU education and given access to this training online to 6,000 professions from more than 30 countries.

It has also contributed to Victoria's testing and tracing efforts by providing a 200-strong physiotherapy team of volunteers to assist on the frontline.

The physiotherapy profession are expert in assisting older people in day-to-day essential activities and support care staff in under-resourced facilities. The profession can be mobilised to wherever additional resources are required.

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Impact of COVID-19 on physiotherapy workforce

The APA surveyed its members employed by aged care service providers; employed directly by residential aged care facilities; sole traders/employed by private practice working in the aged care sector and working with older people/COVID-19 patients in hospitals.

Members reported that they had experienced significant impacts because of COVID-19 at their workplaces. These included:

- Being stood down and/or reduced shifts in all settings. For example, in community due to mass appointment cancellations, in hospitals following elective surgery cancellations, in RACFs introducing the “one site” policy.
- Locked out of sites therefore unable to work/treat residents. Many facilitates do not consider non-direct employees – including allied health practitioners – as essential workers and locked them out.
- Staff shortages due to restrictions and increased sick leave resulting in extended hours and responsibilities of remaining staff
- Increased workload on staff due to reduced social supports for older people across all settings. For example, family, friends and volunteers support physical, emotional and social needs on a daily basis. This may include in walking, with meals and going to the toilet.
- Requirement to be tested and isolate as a result of a positive case
- Mental health/stress resulting of fear of bringing the virus into the workplace as an asymptomatic carrier; fear of being infected at work
- Confusion about latest requirements, availability of PPE, infection control training inadequate and some staff using PPE incorrectly.

Across all workplace settings, respondents reported:

- stress, anxiety and fatigue caused by continually changing workplace requirements
- heightened sense of responsibility and vigilance about infection control
- additional responsibilities resulting from increased staff sick leave and reduced family/social support for older people.

Restricting allied health practitioners to providing treatment at one site only has led to staff shortages, which has burdened remaining staff further.

Practitioners report being stood down or having their hours of work reduced.

As a consequence, some of those who remain are required to work increased hours – but there is still a gap between staffing hours prior to COVID-19 and currently.

Member comments

"It has been a very stressful time. We have moved to dedicated therapist model. Therefore have lost ability to undertake my community therapy work. Previously was doing two days' community, three days' RACF. It has been a very isolating time for us as we no longer have other therapists to assist and gain knowledge and advice from on site. Because we are contractors, it has taken some time to become seen as a 'valued member' of the RACF team. Personally, I have been really challenged with work in terms of my mental health."

"It has been hard to stay motivated and keep a 'brave face'/positivity for our clients. Some issues with PPE and facility not wanting/choosing to provide us with gloves. It has been an anxious time - feeling scared you will either contract COVID-19 at work or you could be an asymptomatic carrier and have devastating affects"

Impact of lockdowns on allied health service provision

Forty-five per cent of APA survey respondents reported being denied access to clients as a result residential aged care facilities lockdowns.

Two large health care providers we interviewed reported a 5% drop in demand for allied health services as a result of lockdowns in the first eight weeks of COVID-19 restrictions.

Many physiotherapy contractors were locked out for long periods – one from March until July in an area with no community transmission. Other physiotherapy contractors continued to access RACFs albeit under changed working conditions, including at one site only.

Privately funded practitioners have been denied access across the country during facility lockdowns though this varies from facility to facility.

One large healthcare provider with 500+ allied health employees is dealing with COVID cases at six sites. All allied health workers at that site must be tested for the virus and quarantine until they receive negative results – creating resourcing pressures.

Allied health professions also report being denied access to clients in areas/facilities where no COVID cases had been reported included indigenous communities in remote areas.

The lockdowns lasted between two-16 weeks, with some in Victoria and NSW still active. They occurred in residential settings where cases of COVID-19 transmission had not been reported and in areas where there was no community transmission.

Member comment

"Dedicated to one RACF only, closure of private practice, unable to treat clients at times due to risk management/ isolation, staffing gaps under or over services - financial loss to company, unable to get resident access to specialised services at times due to visitor restrictions such as external occupational therapy appointments or orthotists or equipment suppliers etc."

Personal protective equipment (PPE)

Only 2% of physios purchase their own PPE. Most PPE is supplied by RACFs (59%) or employers including health care companies and hospitals (35%). Across Australian and all work settings, 64% of respondents reported that they have not have any issues accessing PPE while 36 % reported they did have issues accessing PPE.

Of the 36%, many reported PPE unavailability during the first wave of COVID-19 in March 2020, which have since been resolved. Others are still experiencing restrictions and limits imposed in work places.

Ninety-two per cent wear some form of PPE and the level of PPE worn is a reflection of the geographical location of the workplace and current COVID-19 infection numbers in that state, local area and workplace itself, and the requirements of specific employers.

Almost a third (30%) wear masks and gloves, while a further 28% wear masks only. About 12% wear full PPE – gowns, gloves, masks, eye protection (mostly in Melbourne Metro and NSW hotspots). A small percentage reported wearing face shields.

A further 8 per cent reported wearing no PPE as it was not required in their location (state requirements).

Across the industry, the current frequency of PPE change is:

- After every client: 34%
- After every high risk intervention: 8%
- Once per shift: 8%
- Change masks every 3-4 hours (2-3 masks per shift): 40%
- Other: 10%

Member comment

"In the first lockdown, facility management requested that physio/occupational therapy team use hand soap only as sanitiser was in short supply."

"At the first lockdown, PPE was limited and had to provide myself. Now not enough PPE such as goggles and gown. Sometimes when the gowns are not available, they only provide us with plastic apron which is not enough to cover the arms for any contamination."

Telehealth provision

There have been telehealth access issues reported in all settings. Within in-home care, we understand is used by about 5% of clients. In residential care, we estimate it is only used among 1% of clients.

This service delivery mechanism is not always an option for older people and requires staff investment of time to set up in some cases with no funding available for some patients.

In residential care, there is a reluctance to invest in the staff required to supervise and assist (particularly in the current scenario), a lack of education on its use and efficacy, lack of technology provision and digital knowledge among older people. Staff who would like to use telehealth are not provided with access to the service by aged care providers or their employers. It is viewed as too hard to implement, particularly during a pandemic. However, our view is that this is precisely when alternative modes of service delivery are needed.

Telehealth can be an effective tool to deliver assessment and monitoring and tailored movement programs for many older people if delivered under supervision.

Emerging research indicates that it is possible to deliver services to older people safely via telehealth. While its use is in its infancy, the pandemic has highlighted the need for further education and engagement with the sector about telehealth.

Member comment

"Confusion with protocols about home visiting patients- needing to call in advance, distancing in home setting - clients scared about going outside or accepting help in their homes."

Impact of COVID-19 on health and safety of clients/patients

Ninety per cent of the physiotherapists surveyed reported that COVID-19 had a detrimental impact on the health of their clients/patients.

The issues affecting older people in the aged care system include:

- Mental health and cognitive deterioration due to factors such as isolation, quarantine, reduced physical activity and lack of family/social support. We are aware that people living in RACFs (pre-COVID) who had reduced levels of activity were observed to have low levels of optimism and satisfaction with life; and higher levels of anxiety, depression and loneliness. These have been amplified in the current environment.
- Behavioural issues and discomfort with staff PPE use. Member comment: *"As I am required to wear a mask, sometimes residents that are cognitively impaired are afraid of me."*
- Restricted exercise and movement in all settings leading to physical deconditioning, falls and fractures; pain/increased pain; reduced energy; problems with sleep; pressure injuries and impaired chronic disease management (such as with diabetes)
- Communication issues due to face masks as many older people who have hearing impediments will rely more heavily, compared to others without hearing impairments, on facial cues and may also rely on lip-reading. We know that face masks can also muffle sound, making it harder for speech to be understood.

Keeping older people mobile

It is widely recognised that there are serious and life-threatening implications of restricting both incidental physical activity and more structured exercise in older people. “Unfortunately, the negative consequences of reduced activity are likely to have the greatest impact on function in older people who are frail, who have health conditions, or who already have impaired mobility.” (Physical Activity and Exercise for Older People During and After the Coronavirus Disease 2019 Pandemic: A Path to Recovery).

This is highly relevant to community dwelling older people and particularly following lengthy periods of self-isolation and cancellation of in-home care.

There have been varied responses to addressing this urgent matter within the residential aged care sector. In extremely rare cases, large health providers have reported collaborating with some aged care facilities to ensure residents can exercise and avoid physical decline – even though this is non-compliant with the current ACFI funding model.

Unfortunately, that is not the case generally across the industry where we know residents have been or continue to be confined to their rooms for long periods - eight weeks in some cases - to minimise infection and address staff shortages.

There have been reports of RACFs asking practitioner to sign off on documentation stating they had delivered pain management consultations when no consultation had been held to ensure quotas appear to be maintained. These aged care providers have not expressed interest in exercise programs.

Dementia

The disease progression of dementia is exacerbated by social and physical isolation, and reduction of physical activity. Routines are particularly important in the lives of those living with dementia. Their disruption, due to COVID infection control measures, escalates the illness. The ability to move and explore helps manage dementia behaviours.

The older person living with dementia may not understand what is happening and why they are feeling anxious, confused, fearful and unsettled. They may realise that something is wrong but not understand why. They worry for their children who have stopped visiting them and no longer help them with meals. As a result, RACF staff meals are regularly returning to the kitchen untouched by dementia residents.

There is distress when regular staff who provide a sense of understanding and safety stop attending to the dementia resident.

“That lack of interaction, loss of routine, lack of stimulus had had a deleterious impact on people living with dementia, so their cognitive function has declined more rapidly....these are losses that they won’t regain.” Maree McCabe (CEO Dementia Australia).

There is already evidence of an increase in the progression of dementia symptoms during the lockdown that we are monitoring. Dr Melanie Wroth, Chief Clinical Advisor, Aged Care

Quality and Safety Commission has said it is vitally important for family to remain involved with the care of their loved one living with dementia through the current crisis.

Dementia behaviours are escalating due to confinement and reduced staff and social support. With reduced staffing and constant change in managing COVID in RACFs, these behaviours are increasingly medically managed with the use benzodiazepines, antidepressants and, at times, anti-psychotics. We are seeing more falls among people living with dementia resulting from these interventions.

Residential aged care facilities (RACF)

PPE use: 91% of RACF physios report using some form of PPE as a requirement of their employers. Thirty-eight per cent reported use gloves and masks; 18% wear masks only, 13% wear gowns, gloves and masks. The 9% who report not wearing PPE work in geographical locations that do not have PPE use mandated.

PPE provision: Most physios working in RACFs (82%) are provided PPE by the RACF with 14% (contractors) accessing PPE from their employers (health care providers).

PPE access: About 60% of RACF physios reported no issues accessing PPE. The remaining 40% reported issues of limited and/or restricted availability at RACFs – many of these refer to supply problems at the onset of COVID-19 that have since been resolved. Some members report mandating mask use has resolved previous access issues to these items. Of those 40%, two thirds continue to report some PPE access issues, including:

- Aged care providers not supplying PPE and seeking that practitioners provide their own
- Aged care providers restricting PPE for use in COVID cases only
- Employers and aged care providers stipulating different usage guidelines (in the case of contractors)
- Supply of inadequate PPE such as plastic aprons without sleeves for use in both COVID and non COVID environments
- Shortage of sanitiser widespread

One Melbourne respondent wrote: "*We had no masks. After masks became mandatory in aged care, we were provided with stock within 48hrs.*"

In residential aged care facilities, physiotherapists reported their PPE wear in the workplace consisted of:

- Gowns, masks, gloves, eye protection: 11.4% (almost all in Melbourne Metro area)
- Gowns, masks, gloves: 13%
- Masks, gloves: 38%
- Masks only: 18%
- Gloves only: 20%. (mostly Queensland)
- None: 9% (in areas outside of Victoria and NSW hotspots)
- Other: 7% (situation dependent)

PPE change frequency: Changing PPE after each client seems to be the most common approach in RACFs (42%) with a further 30% changing masks every four hours and gloves after each consultation. Seven per cent change PPE after high-risk interventions only, while a further 7% only once per shift. Concerningly, about a third of those in the latter group work in Metropolitan Melbourne.

PPE training: satisfaction: 75% satisfied, 25% dissatisfied

Pressure to attend work: 21% of respondents report feeling pressured to attend work due to staff shortages. One member wrote: "Increased carers leave due to school closures and children home from school with colds, as well as increased staff sick leave due to high infection precautions means there is higher staffing levels required to cover."

COVID-19 exposure: 40% of respondents were aware of one or more physiotherapists who have been exposed to a COVID-19 positive client/patient in the course of their ordinary duties. About 40% knew of one of more physiotherapists who had come into contact with a COVID-positive co-worker.

Department of Health information provision: 73% were satisfied, 27% were dissatisfied. Many members commented that inconsistent messaging about hygiene and PPE created stress in the workplace.

Work hours: 50% report work hours unchanged, 35% report hours have decreased and a further 15% hours have increased. This reflects what members are telling us – that staff shortages due to "one site" policies; restricted access for some allied health contractors and/or increase in sick leave have led to increased burden for remaining staff. Some aged care providers were also trying to "do the right thing" by allied health workers restricted to one site and hence losing work hours – by increasing their hours at the site where they were permitted to attend.

Effect of Visitation Access Code

- Improved patient well being: 52%
- Improved access to allied health practitioners: 9%
- Increased risk of COVID transmission 15%
- Remainder: unsure, no effect or had not heard of the Code (5%).

Pain management versus mobility and exercise prescription

In residential aged care, only 75% of older people are eligible for physiotherapy and other allied health treatment under the Aged Care Funding Instrument (ACFI).

The remaining 25% do not have access to physiotherapy and other allied health therapy.

The ACFI funds passive treatments to manage pain. Under ACFI provision clauses 12.4a and 12.4b, older people can access one-on-one individual physiotherapy care for complex pain management – limited to massage therapy and pain management involving technical equipment.

There is no funding for provision of restorative and reablement care or episodic care, including exercise provision to maintain conditioning, strength and balance, and prevent falls.

This model is abjectly insufficient and inflexible in enabling consumer-centric, tailored and appropriate care of older people. It does not enable resident choice at a time when RACF residents are asking for physiotherapy-led exercise programs to help them overcome the effects of restriction on movement.

We also understand there is a cohort of physiotherapists who have provided tailored physiotherapy treatment within their scope of practice to address the impacts of COVID-19 where they can. This makes them non-compliant with current guidelines.

Member comment

"I try to help the residents with exercise when I can even though I'm technically breaking the law to do that! I can see their conditions deteriorating and feel helpless."

Impacts of COVID-19 on physios/practice in RACFs

- Stress and anxiety and other mental health issues about COVID-19 transmission and workplace changes
- Restrictions on movement between work sites resulting in fewer allied health practitioners available at many sites and increased workload for others
- Constantly changing infection control requirements
- Change in/greater complexity in patient profile as hospitals adjust services to COVID relief
- Confusion and inconsistent messaging about PPE use
- Reduced social support for patients means a greater burden on staff
- Increased staff sick leave due to COVID testing and isolation requirements increases burden on remaining staff.

Member comments

"It is difficult to train staff when you cannot directly induct them. Minimal guidelines for PPE use and who wears what seems random."

Impacts of COVID-19 on RACF residents

In the RACF setting, the issues reported included:

- Loneliness, anxiety and mental health decline contributed to by isolating/quarantining in room, disruption of routine, unfamiliar staff and other factors
- Deterioration in cognitive condition as a result of lack of exercise and social contact
- Physical deconditioning as a result of lack of exercise
- Increase in pressure injuries
- Increase in falls (see graph below)

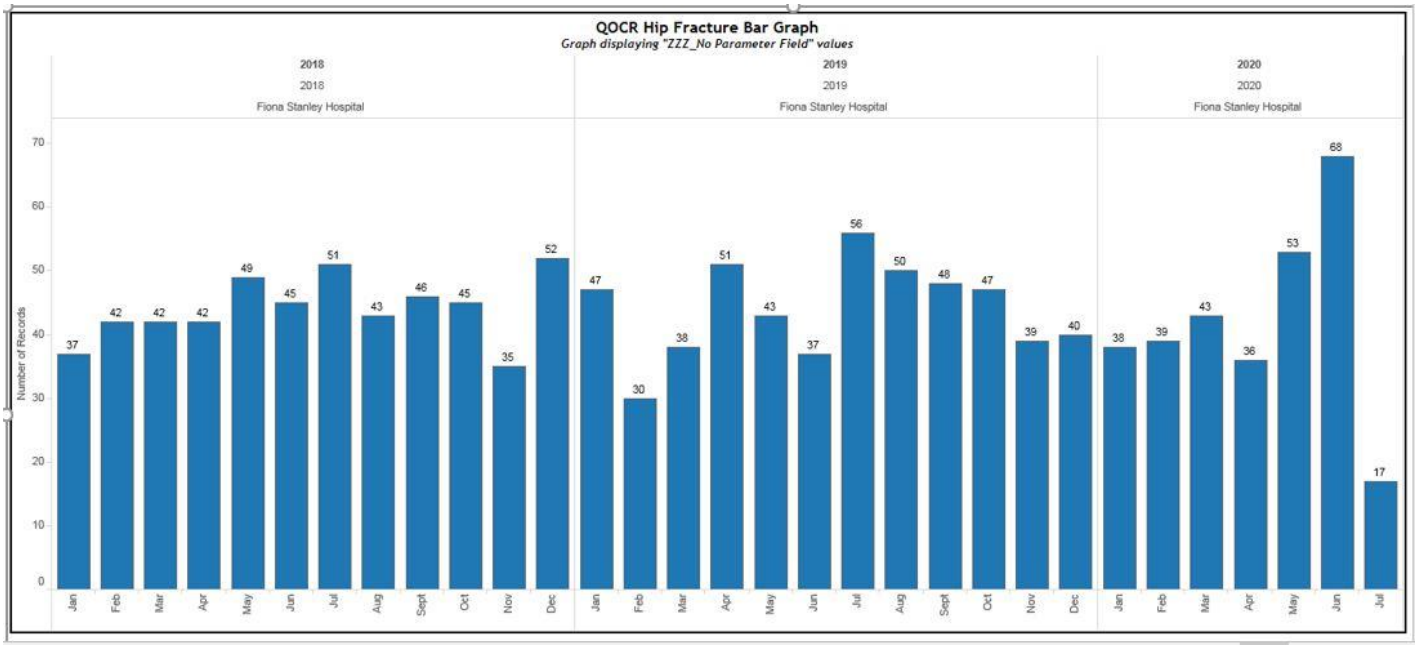
Member comment

"The loneliness of residents whose families are unable to visit is heart wrenching. The impact on mental health of residents has been significantly affected."

Hip fracture presentations at WA Fiona Stanley Hospital

The graph below illustrates the increased number of hip fracture presentations at the Fiona Stanley hospital during COVID-19 compared to previous periods. There were 36 hip fracture presentations in April, 53 in May and 63 in June 2020, the highest number of any month in the past 2.5 years. This demonstrates the impact of lack on mobility on older people resulting in falls and fractures.

Anecdotally, practitioners at hospital in other states are also reporting increases in falls.



Hospitals

Seventy-three percent of respondents work in Melbourne metro; 16% in NSW and the remainder across Australia.

PPE use: All hospital employees report wearing some form of PPE as a requirement of their employers. The majority (53%) reported wearing masks only; 21% wear masks, gowns, gloves and eye protection; 16% wear gloves and masks only while the remainder wear a combination of items including a small percentage who report wearing face shields.

PPE access: About 90% of hospital staff reported no issues accessing PPE.

PPE change frequency: Changing PPE every four hours appears to be standard rule of thumb in the hospital setting (68%) when dealing with low-risk patients. Among this group, more frequent changes are required if dealing with high risk patients, when leaving a ward or when masks became damp; gloves soiled. About 10% of respondents reported changing PPE after each client; 15% once per shift; 5% after every high-risk intervention.

PPE use training: 95% satisfied, 5% dissatisfied

Pressure to attend work: 14% of hospital-based respondents reported feeling pressured to attend work by their employer.

COVID-19 exposure: 50% of respondents were aware of one or more physiotherapists who have been exposed to a COVID-19 positive client/patient in the course of their ordinary duties. About 25% knew of one of more physiotherapists who had come into contact with a COVID-positive co-worker.

Department of Health information provision: 68% were satisfied, 21% were not satisfied, 10% other

Impacts of COVID-19 on physios/practice in hospital settings

- Being stood down as result of elective surgery shutdowns and reduction to other non-urgent services
- Stress and anxiety about COVID-19 transmission, including asymptomatic transmission, and workplace changes
- Restrictions on movement between work sites resulting in fewer allied health practitioners available at many sites and increased workload for others
- Constantly changing infection control requirements
- Change in/greater complexity in patient profile as hospitals adjust services to COVID relief
- Confusion and inconsistent messaging about PPE use
- Reduced social support for patients means a greater burden on staff
- Increased staff sick leave due to COVID testing and isolation requirements increases burden on remaining staff

Member comment

"I was being stood down as a casual for a month when surgeries reduced in the 1st wave. Influx of patients in public hospital when wards were converted into nursing home wards so patients were moved into our ward. Stress and overtime with understaffing on our ward. Changing protocols with mask wearing created confusion. Influx of patients admitted to outpatients or home visiting services due to the need to get them out of hospital wards to free up beds. This means reduced level of care and patients really needing good rehab. Increased cleaning requirement from physio staff that are not outsourced to cleaning staff, inconsistencies in polices between areas/departments causing confusion/anxiety."

Impacts of COVID-19 on patients in hospital settings

In the hospital setting, the issues reported included:

- Reduced access to allied health service. One member wrote: *"There is only one allied health assistant on Thursdays and Fridays with no service on the weekend for 30 beds – increasing deconditioning in patients."*
- No social supports for COVID-positive patients and reduced social support die to reduced visiting hours for other older patients
- Physical deconditioning resulting from reduced social supports and restrictions to movement. One member wrote: *"Patients are unable to leave their rooms without a nurse of physio. This means patients who would normally progress walking distance and physical activity independently are unable to. This had led to longer length of stay."*
- Increase in falls and pressure injuries
- Complexity of discharge planning to ensure appropriate safety and support and reduced access to community care

Member comments

"No family to assist, increased falls in hospital, increased functional decline."

"Patients are unable to leave their rooms without a nurse or physio. This means patients who would normally progress walking distance and physical activity independently are unable to. This has led to longer length of stay and reconditioning."

"Reduced treatment and assessment quality due to understaffing prior to COVID19 then adding in staff sickness, influx of patients to other wards due nursing home residents needing to take up beds. Trying to get patients out of hospital wards into the outpatients and home setting. Reduces quality of care."

Asymptomatic transmission

Another physiotherapist at a hospital spoke of the distress among hospital staff at asymptomatic transmission. They reported that 100 hospital staff, two of them physiotherapists, had tested COVID-positive.

The level of asymptomatic transmission among staff is of great concern. They had not displayed any symptoms, worn masks and face shields and "did all the rights". However, they came into contact with patients on non-COVID wards as part of their daily work. As a result, two "cold (non COVID wards) were shut down and some patients became infected.

Hospital transfers from residential aged care facilities

A number of hospital-based members have reported a lack of adequate handover from RACFs of COVID-positive and other RACF residents to hospital, requiring hospital staff to invest unnecessary time in establishing basic patient information. The issues most frequently experienced by members include:

- Lack of bed availability
- Receiving little or no warning about the transfer
- Identification issues caused by not the patient not having an ID or their usual care staff being in isolation
- Communication issues because of the patient's condition (eg dementia) or CALD background
- No social support
- Increase in presentation for falls and pressure injuries

The survey also identified multiple discharge issues, including

- Facilities not accepting residents back post discharge
- Difficulty arranging ongoing social supports for those returning to the community
- Difficulty arranging inpatient rehabilitation

Member comments

"Facilities are refusing to take residents back or accept new residents into their care. Residents are being forced to remain in hospital for longer with every day in hospital a high risk of developing a hospital associated complication, the situation is dire for these residents."

"*When COVID-affected RACF residents were transferred to hospital, there was very little handover. Residents were arriving with no ID, dementia and non-English speaking background patients could not identify themselves, leading to a scramble for doctors and nurses to identify patients, establish Not for Resuscitation status and set up goals of care."*

"Residents arriving in various states of neglect (pressure sores, malnourished, bed bound))."

Home Care

Eighty per cent of survey respondents are employed by healthcare providers, 10% are sole traders and a further 10% are employed by hospitals.

Large health care providers report losing 50% of their appointments in the first three weeks of COVID-19. This lifted to higher levels than pre-COVID by mid-June as clients attempted to make up for lost appointments.

Stage 4 restrictions in Victoria and the emergence of some hotspots in NSW have seen in-home appointments plummet again as community fear of transmission increases. The take

up of telehealth as a viable service delivery option has not eventuated in this sector as healthcare providers – employers of the majority of in-home practitioners – grapple with staffing and risk management issues. In most cases, the client would require supervision to use telehealth.

Other allied health practitioners report examples of management who prohibited allied health practitioners from face-to-face consultations citing lack of access to PPE as the reason, eg speech pathologists from seeing any clients face to face due to saying that they didn't have access to PPE or relevant training to use it. Clients with swallowing difficulties (at highest health risk) did not get seen at all because of concerns about the potential transmission risks/PPE needed for this work.

PPE use: 30% use masks and gloves, 30% gloves only, 30% none and 10% gloves only.

PPE provision: 80% of physios working in home care are provided PPE by their employer, with 20% purchasing their own.

PPE access: 80% had issues accessing PPE

- Sole traders sourcing PPE through retail suppliers have experienced shortages and high mark ups
- Many reported issues with mask provision during the first wave that have since resolved
- Ongoing rationing of supplies remains an issue for some. Member comment: *"Shortages of hand and surface sanitiser early in the pandemic forced our organisation to use other costly or time-consuming-to-prepare materials. Ongoing rationing is still resulting in inefficiencies."*

In home practitioners reported their PPE wear in the workplace consisted of:

- Masks, gloves: 30%
- Masks only: 30%
- Gloves only: 10%.
- None: 10%
- Other: 7%

PPE change frequency: Changing PPE after each client seems to be the most common approach among in home practitioners (45%) with a further 25% changing masks every four hours and gloves after each consultation. Ten per cent change PPE after high-risk interventions only, while a further 20% once per shift.

PPE training: satisfaction: 60% satisfied, 40% dissatisfied

Pressure to attend work: 30% of respondents report feeling pressured to attend work due to staff shortages.

Satisfaction with Department of Health information: 50% satisfied

COVID-19 exposure: 30% of respondents were aware of one or more physiotherapists who have been exposed to a COVID-19 positive client/patient in the course of their ordinary duties. About 20% knew of one of more physiotherapists who had come into contact with a

COVID-positive co-worker. 10% said they knew of a physiotherapist who had contracted COVID in the workplace.

Work hours: 50% report work hours unchanged and the remaining 50% report experiencing decreased work hours.

Impacts of COVID-19 on physios/practice in home care

- Confusion about restrictions
- Lack of PPE and inconsistent PPE use requirements from employer to employer and between different practitioners
- Confusion about appropriate PPE and inconsistent levels of training
- Being stood down and loss of work hours due to mass appointment cancellations
- Stress and anxiety about COVID-19 transmission, including asymptomatic transmission, and workplace changes
- Losing home care clients due to "one site" restrictions
- Loss of private clients in RACF
- Some employers stopped face-to-face appointments to manage risk

Member comments

"The stress of deciding each day whether I should go to work. Having to cancel and inconvenience patients (and other workmates) on the days that I take off sick, and when I am waiting for test results. Certainly stress around passing the virus onto my patients."

"No access to PPE provided by employer. Decreased workload to 75% of normal and no access to JobKeeper to assist with financial difficulties. Anxiety in working in community and being infected or infecting others."

Impacts of COVID-19 on home care clients

In home care clients have been reported to:

- Physical, mental and cognitive deterioration as a result of cancelling/putting on hold appointments
- Anxiety about allowing practitioners into the house
- Fear of asymptomatic transmission
- Concern about different levels of PPE worn by different health practitioners and other support providers
- Increased in falls and physical deconditioning

Member comments

"Clients don't have any family to help them. Those who usually quite outgoing really feel isolated and frustrated that they can't access their bank or shops to buy goods and we aren't meant to help them. Some clients are concerned that other providers e.g. cleaners, are not wearing masks at this stage (30/07/20)"

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Solutions

Amend ACFI provisions to align with evidence-based interventions, particularly exercise provision

The removal of normal activities over several months has had a significant impact on the health of older people in RACF. RACF residents are asking their physiotherapists to provide them with exercise-based programs in the absence of even incidental exercise in many cases.

The current archaic Aged Care Funding Instrument (ACFI) model denies any form of physiotherapy treatment to 25% the older people in RACF. In the remaining 75%, the model does not support the delivery of full, patient-centred care and does not enable flexibility to treat urgent and emerging issues.

Under the Aged Care Funding Instrument (ACFI), aged care facility residents can access one-on-one individual physiotherapy care for complex pain management – limited to massage therapy and pain management involving technical equipment.

12.4a – one session per week (used by approx. 10% of residents)

12.4b – four sessions per week (used by 52.62% of residents)

COVID-19 has demonstrated that restrictive models of care are having significant detrimental impacts on older people access.

Amending the definitions of the 12.4a and 12.4b provisions – by way of a legislative instrument or COVID-19 emergency order – is a cost neutral measure for the existing 75% of RACF residents currently entitled to physiotherapy care.

Funding for the remaining 25% of RACF residents would be required.

This measure could be temporary but we recommend it is adopted ongoing until new approaches by government are adapted as there will be long-term rehabilitation requirements.

Physiotherapy and COVID-19 recovery

Physiotherapy is vital in both acute and post-acute COVID-19 rehabilitation, and short-term rehabilitation where usual care has been suspended.

It is integral in treating post intensive care syndrome, and post-viral fatigue. Importantly, the profession should be at the forefront of rehabilitation for older people in dealing with the impacts of lockdowns and social isolation.

According to the World Confederation of Physical Therapy *(Appendix A: World Physiotherapy Response to COVID-19 Briefing Paper 2: Rehabilitation and the Vital Role of Physiotherapy)*:

- There will be increased demand for rehabilitation professionals working in acute and critical care settings, and action is needed to ensure staffing requirements are met.
- There will also be increased demand for specialised longer-stay rehabilitation, especially for older people who will frequently require these services, and those with co-morbidities.
- Physiotherapists should be involved in the planning of service delivery at a strategic and operational level.
- Practice needs to adapt to the changing context of delivery and emerging evidence.
- Absence of physiotherapy rehabilitation provision will have long-term consequences leading to increase need and potentially increased disability.
- Integrated care planning for those individuals with long term needs will require multi-professional and inter-sectoral cooperation across settings, including the home environment.

Recommendation

Rehabilitation and COVID recovery: invest in COVID-19 rehabilitation in the community with a dedicated MBS-funded Recovery Card. Acting in the same way as a Veteran's Gold Card; the COVID-19 Recovery Card would entitle those affected by the virus to access the consumer-driven, evidence-based interventions.

Consultation and welfare checks via telehealth

Telehealth – via videoconferencing and phone – is a viable and effective form of service delivery for many physiotherapy interactions at a time of social distancing.

However, it should not be seen as a replacement for future face-to-face rehabilitation and telehealth via videoconference has not been a viable option for all, reflecting differences in the access to and comfort with technology.

COVID-19 has demonstrated numerous obstacles to increased telehealth take up among older people at a time when it is most needed. Videoconferencing support is required and the use of phone telehealth should not be overlooked.

Recommendation

Urgent provision of iPads and additional staff resources to supervise their use in RACFs to enable care provision via telehealth and engagement with families and friends, particularly in COVID hotspot areas.

Recommendation

Establish a multidisciplinary Aged Care COVID-19 Response Team to conduct daily telehealth (phone) welfare checks on older people in the community to ensure they are receiving the health care they require.

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Patient-centred and appropriate ongoing funding of RACF

For too long, allied health has been viewed as non-essential, an optional extra within the RACF. COVID-19 has brought into sharp focus that the opposite is true and a growing awareness of its importance in maintaining mental, physical and cognitive function.

The current archaic funding model denies access to any form of physiotherapy treatment to a quarter of the older people in RACF. Its narrow focus does not support the delivery of full, patient-centred care and does not enable flexibility to treat urgent and emerging issues.

COVID-19 has demonstrated that the time must be up for restrictive models of care that deny older people access to and choice of treatment.

The APA supports a two-tiered aged-care funding model distributed via RACFs, independently assessed and overseen. This would include a foundation layer for ongoing care determined by the needs of the older people and assessed by an independent tool. This layer must to be underpinned by shared delivery and accountability of a multidisciplinary team.

This must be supplemented with a substantial layer of funding for short-term or episodic care encompassing restorative and reablement care to help prevent injury and decline and to post illness or falls.

Recommendation

Introduce a two-tiered funding model that funds the ongoing, independently assessed care needs of older people, supplemented by a substantial additional layer of allied health funding for restorative and reablement care.

Case study A: patient decline during isolation

Mr X is a 75-year retired engineer and academic, who loved travelling and being outdoors. Mr. X has been living with a progressive neurological condition, mild cognitive impairment, chronic pain, depression and anxiety for several years. At the beginning of the year, he was living on his own with cleaning support services. However, after a series of falls he became unable to care for himself at home and moved into residential aged care.

Prior to COVID-19, he was ambulating short distances with a four-wheel seat walker in the facility with stand-by assistance. His family visited daily to assist him with extra walking practice and emotional and social support.

When the COVID-19 restrictions were implemented, his physical activity was restricted to his room and his family were excluded from visiting. A visiting window area was set-up, however, by this time, Mr X was too fearful to leave his room, in case he would catch the virus.

After the release of the Visitation Access Code, his family were permitted to visit face-to-face. Mr X was no longer able to stand without the use of a standing aid, no longer walking and experiencing an increase in his pain levels. His family commented that his cognition, mood, behaviour and motivation had deteriorated.

Mr X was still fearful of leaving his room even for meals. Staff commented that he was no longer able to manage cutlery to cut up his food or hold a full glass of water. There were concerns that his fluid intake was compromised. The adverse effects on Mr X of social isolation, the restrictions to movement and human contact have negatively impacted his overall health and wellbeing.

Mr X and his family engaged private physiotherapy services to help him get moving again. Since he began private physiotherapy, he had embarked on a restorative programme tailored to his specific goals. Although it has only been three weeks, he is now smiling and beginning to laugh again – his mood being noticed by others as ‘lighter’ and with less irritability towards staff. He is remembering names, less anxious and now able to walk a few metres. He is able to hold a small glass of juice and his pain has improved.

The ability to now access physiotherapy to work towards restoring functional ability has given Mr X hope and contributed to an increased sense of wellbeing.

Case study B: independent living and post-COVID recovery

Prior to COVID-19 Mr and Mrs X lived in their own unit with no formal home care services. Mr X is 80 and was the carer for his wife. Mrs X, aged 70, has a progressive neurological condition. Mr X is his wife's carer helping her with most ADLs, such as showering and dressing, and walking.

In March 2020 they contracted COVID while on holidays. Upon returning home Mr X was admitted to ICU. Mrs X experienced minimal symptoms and her family tried to get some acute home care services to keep her a home but were unsuccessful. She was admitted to the local hospital.

Mrs X had difficulty securing an ACAT assessment and subsequent nursing home respite due to her COVID-19 history. She remained in hospital for more than a month before she could access respite. While on respite, she participated in minimal physiotherapy and her mobility and balance further deteriorated.

In April Mr X was discharged home after spending 3 weeks in hospital. He was discharged with an outpatient 'hospital in the home' two-week program to start his rehabilitation. This could not start until his 10-day post hospital quarantine period had expired. During this time, he had no support.

In May Mrs X returned from respite once it was ascertained by ACAT that Mr X could care for his wife. ACAT advised that Mr X should apply for home care services. Mr X had problems with Centrelink as they refused him entry to complete his forms for home care support due to his recent history with COVID-19.

In June Mr and Mrs X were approved by their local PHN to join the pulmonary rehabilitation service. This allows them both to access respiratory specialist review, OT, physio and nursing support and provide them with an individual exercise program via telehealth. This has dramatically improved their breathlessness, fatigue and ability to remain at home.

In July ACAT provided approval for a home care package for Mrs X. She is now on the waiting list.

Conclusion

COVID-19 has shone a light on deficiencies in the aged care system that the APA has been highlighting for a number of years. It is clear action is required to address the increased decline of physical, mental and cognitive decline in older people resulting from COVID-19 lockdowns, social isolation and lack of social support. We must also embrace a forward looking approach to meet the health and wellbeing needs of older Australians in long term COVID rehabilitation and recovery..

Australian Physiotherapy Association

The APA vision is that all Australians will have access to quality physiotherapy, when and where required, to optimise health and wellbeing, and that the community recognises the benefit of choosing physiotherapy.

The APA is the peak body representing the interests of Australian physiotherapists and their patients. It is a national organisation with state and territory branches and specialty subgroups. The APA represents more than 28,000 members who conduct more than 23 million consultations each year.

The APA corporate structure is one of a company limited by guarantee. The APA is governed by a Board of Directors elected by representatives of all stakeholder groups within the Association.

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Appendix A - PDF

World Physiotherapy

World Physiotherapy response to COVID-19

Briefing paper 2

REHABILITATION AND THE VITAL ROLE OF PHYSIOTHERAPY

COVID-19 CORONAVIRUS

May 2020