Transcript

Aged Care Quality and Safety Commission

Alternative Approaches to Chemical Restraint

 **Presented by:**

**moderator:**

Kyle Olsen
Older Persons Advocacy Network (OPAN)

**Panellists:**

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Felicity Baker
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Geoff Rowe
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[The visuals during this webinar are of Kyle Olsen speaking to camera and other speakers presenting in turn via video, with reference to the content of a PowerPoint presentation being played on screen]

**Kyle Olsen:**

Hello. My name’s Kyle Olsen and I’d like to welcome you to this webinar which is the first in a two-part series called Alternative Approaches to Chemical Restraints proudly produced by the Older Persons Advocacy Network and funded by the Aged Care Quality and Safety Commission.

[*Visual of slide with text saying ‘Alternative approaches to Chemical Restraint’, ‘Presented by OPAN’, ‘Older Persons Advocacy Network’, ‘Funded by Australian Government with Crest (logo)’, ‘Aged Care Quality and Safety Commission’*]

Before we begin we at OPANwould like to acknowledge and pay our respects to the Gadigal people of the Eora nation, the traditional owners of the land on which we work and are currently filming. We pay respect to their Elders past, present and emerging. Always was, always will be Aboriginal land.

In Australia there’s been increasing and ongoing concern about the use of chemical restraint in aged care particularly for people living with dementia or who have a cognitive impairment. Dementia can cause changes in behaviour but far too often medications are prescribed to manage these changes without understanding what’s causing the change. At the recent Royal Commission into Aged Care Quality and Safety it was reported that 61% of residents in aged care were regularly taking antipsychotic and/or benzodiazepine agents. And an expert panel estimated that it was only justified in 10% of the cases.

Last year OPAN produced a six part webinar series called Medication. It’s Your Choice. We covered topics including what is chemical restraint, living with dementia, a person-centred approach, the medications used, supported decision making and informed choice, as well as alternative approaches and safe and inclusive care. Now if you’d like to watch these webinars then please head to our Medication. It’s Your Choice website. And the address is opan.org.au/yourchoice. Now apart from the webinars you will find some easily accessible information including a brochure and pamphlets which you’ll be able to download and print as well as our explainer video. Now as a refresher let’s have a look at a snippet of it now.

[START VIDEO PLAYBACK]

§(Music Playing)§

**Speaker:**

How much do you know about the medication you or a person you care for is taking? Did you know that taking medication is your choice and that you control what you take?

It doesn’t matter what age you are or if you have any medical conditions. You never lose the right to have control over your decisions including decisions about your medication or how you wish to live your life. And this is further clarified by the Charter of Aged Care Rights.

§(Music Playing)§

[*Visual of slide with text saying Medications & your health’*]

Medications can play an important role in helping you live comfortably, to stay safe and to live longer.

However sometimes medications may not work as expected, can make you feel unwell and can bring on unwanted side effects or changes in behaviour. Some medications in particular such as those that change behaviour or can make you feel drowsy are known to be overused in Australia amongst older people. This is despite strong evidence showing these drugs are not only ineffective in many cases but can lead to increased falls, fractures and confusion amongst older people, as well as an increased risk of pneumonia, stroke and even early death.

These medications can also reduce your awareness, ability to interact and ability to experience joy which can in return make you feel distressed, disoriented or isolated.

[END VIDEO PLAYBACK]

**Kyle Olsen:**

In episode five of that series we looked at a whole range of alternative approaches to chemical restraint. Now in that episode we focused more on the theory behind the approaches and looked at the what and the why of each approach. Now in this two part follow up webinar series we want to take a more practical approach for aged care workers and also focus on how these approaches can be implemented.

So in today’s webinar we’ll look at the revised legislation that comes into effect from tomorrow regarding the use of chemical restraints as well as the new rules that all providers must follow. Now these both came about as a result of the recent Royal Commission into Aged Care. We’ll recap on the impacts of chemical restraints in aged care and we’ll then discuss how unmet needs can cause changes in behaviour and look at the importance of implementing a person-centred approach. As we said we want to make this webinar as practical as possible so we’ll look at practical strategies and approaches to support a person-centred approach and today we’ll use music therapy as an example.

And we’ll finish off today’s webinar with a live Q&A where our panellists will answer the questions you either submitted when you registered for today or that you’ve thought of during the webinar. So if you do think of something that you would like to ask or a comment that you’d like to make please put it in the comment box which is under the video and we’ll do our best to answer as many as we can in the time that we have. And remember if you’d rather speak to a professional advocate you can always call OPAN on 1800 700 600 and you’ll be connected with an aged care advocate from your state or territory.

Right. To help us navigate all of this I’d like to welcome and introduce our panel of guests. Associate Professor Stephen MacFarlane is Head of Clinical Services at The Dementia Centre. Hi Steve. Thanks for joining us. It’s a pleasure to have you on the panel.

**Stephen MacFarlane:**

It’s a pleasure to be here Kyle and welcome to all your viewers from around the country.

**Kyle Olsen:**

Thanks mate. Felicity Baker is a Professor of Music Therapy at the University of Melbourne. Hi Felicity. It’s really great to have you back on the panel again.

**Felicity Baker:**

Thank you Kyle. It’s great to be here and I’m looking forward to the discussion today.

**Kyle Olsen:**

Lyn Robb is the Dementia Engagement Modelling Program Lead at the Dementia Centre HammondCare. Hi Lyn. It’s a pleasure to meet you. Thanks for your time today.

**Lyn Robb:**

Good morning Kyle and everyone. It’s a pleasure to be here.

**Kyle Olsen:**

And Geoff Rowe is the CEO of Aged and Disability Advocacy Australia. G’day Geoff. It’s always a pleasure to have you on the panel.

**Geoff Rowe:**

Morning Kyle. Great to be here.

**Kyle Olsen:**

Right. Let’s get underway. Now Steve you presented evidence to the recent Royal Commission into Aged Care Quality and Safety on the over-reliance of chemical restraint in aged care amongst other things. But before we get into looking at the revised legislation and new rules regarding their use can you start off by breaking it down for us into layman’s terms? What is meant by chemical restraint or restrictive practices?

**Stephen MacFarlane:**

[*Visual of slide with text saying ‘What is Chemical Restraint or Restrictive Practices?’, ‘OPAN’, ‘Older Persons Advocacy Network’*]

Okay. Well I guess chemical restraint is one face of restrictive practices. There are a number of restrictive practices that were singled out by the Royal Commission and they include chemical restraint but also such things as environmental restraints, mechanical restraint, physical restraint and seclusion. So those are the several types of restrictive practices covered by the Commission in the recommendations.

Chemical restraint in particular refers to the prescription of any medication where the primary intent is to affect behaviour. There’s a couple of problems remaining with the modified definition of chemical restraint however because there are still some exclusions within the definition whereby you can still prescribe a psychotropic according to the regulations for the treatment of a diagnosed physical disorder, for the treatment of a diagnosed mental or neurological disorder, and my concern is that prescribers will view the behaviours that we see in the setting of dementia as being part of the treatment of the underlying dementia that needs to be managed. So I’m not sure that changing the definitions of chemical restraint as the Royal Commission has recommended will necessarily achieve the desired outcome in itself.

But to me the intent behind the prescription is key. If clearly the intent of the prescriber is to sedate a person or to alter their behaviour in some way then that’s not really a symptom of the condition that they’re treating. It’s a person’s response to the difficulties that they find themselves in as a result of their condition. And I think it’s hair splitting to try and pass it out in too much detail but those are the general principles.

**Kyle Olsen:**

Thanks Steve. Just picking up then from that, from your experience and research how often is chemical restraint over-used on and on the other hand in what instances can it be prescribed?

**Stephen MacFarlane:**

Okay. The second part of the question is easy to answer first. It can be prescribed in emergency situations certainly where life and limb and property are at imminent risk. It can also be prescribed as a treatment of last resort after all other reasonable avenues have been explored. And that’s an emphasis that’s important because what’s reasonable in one environment, in one geographic circumstance, at a particular time of day for example, may be reasonable and feasible at one point but not in other settings.

So in terms of the over-use the research and my experience are probably two different things because of the role that I hold at the moment. The research you mentioned in one of your introductory slides shows that 61% of all aged care residents are prescribed either a benzodiazepine or an antipsychotic. Not all aged care residents live with dementia however but between 50% and 70% of them do. If you look at the rates of psychotropic prescription not just in aged care residents as a whole but in people living with dementia as a subset of aged care residents then those rates can go up to between 70% and 80% depending on which study you cite which is really tremendously high and shows that these non-pharmacological approaches are not being used as a first resort but that medication really is a first resort. To illustrate that if you look at data from the Australian Bureau of Statistics that shows the rates at which people over the age of 65 are referred for psychological services, so consultations by psychologists and so forth, the rates of psychology utilisation in the over 65s are the lowest in the country with the exclusion of preschool aged children, yet the rates of psychotropic prescription in the over 65s are the highest in the country by a factor of two or three compared to middle aged adults.

Now in my experience because my role sees me with DSA reviewing people’s medication it’s invariable of the cases that I’m asked to review are already prescribed a psychotropic medication and that’s why I’m being involved. So the non-pharma approaches of DSA are being sought only after people have already been prescribed these chemical approaches. So the cart is being put before the horse Kyle.

**Kyle Olsen:**

Thanks Steve. In its final report the Aged Care Royal Commission stated the overuse of restrictive practices in aged care is a major quality and safety issue. Urgent reforms remain necessary to protect older people from unnecessary and potentially harmful restraint. OPAN is pleased to report that as of tomorrow a revised legislation comes into effect that regulates the use of restrictive restraints which were formerly referred to as chemical restraints. Geoff can you please run us through the revised legislation and let us know what the changes are?

**Geoff Rowe:**

Look I’m really happy to do that Kyle but I really wanted to start I guess with a word of encouragement. Back in the late 2000s I worked in the disability sector in Queensland and at that time the Queensland Government made it unlawful to use any form of restraint on people with a disability. I was working for a large organisation and we identified about 750 of our clients who were subject to restrictive practices and so we set about looking at alternatives to chemical restraint, to physical restraint and to other options. And over a period of four years we moved from 750 residents being subject to restrictive practices to only 100. So it’s possible, it can be done, and the outcome for the individual is much better. They’re able to participate more.

But back to the legislation. I guess one of the things about the legislation is it’s not a one size fits all approach. It really emphasises the individual care and reinforces the rights of aged care recipients. It does provide a strengthening and clarification of the definition of restrictive practices as well as clarifies the consent requirements that are required by service providers so it helps them understand what their obligations are when it means you have to get consent. It also ensures as Steve was saying that restrictive practices are a last resort and they’re a last resort to prevent harm after all of the other options that are available have been considered and have been applied.

**Kyle Olsen:**

Thanks Geoff. So can you also then run us through the new rules that a provider must follow when using restrictive practices?

**Geoff Rowe:**

Happy to do that Kyle. The new rules really provide that restrictive practices in relation to a care recipient, so an aged care recipient, can only be used as we’ve talked about as a last resort to prevent harm to the care recipient or other persons. And we also have to look at the consideration of the likely impact of the use of restrictive practices on the care recipient. So we do know that chemical restraint particularly there’s lots of side effects and lots of very negative outcomes for the individuals.

We also need to make sure that there is evidence, that there’s documented evidence that the alternative strategies have been considered or used in relation to that care recipient. So again if challenged as aged care workers we’ve got to be able to say that we have tried a whole range of options. The restrictive practice in relation to an aged care recipient must be only used to the extent that it’s necessary and be proportionate to the risk of harm that the care recipient is likely to experience or to impose on others.

And I guess the rules provide that if the restrictive practice to a care recipient is used it must be used in a less restrictive form. So the use of restrictive practices whether it be a physical restraint or whether it be a chemical restraint, it needs to be really starting at the low end rather than going in with all guns blazing.

And the final rule that I wanted to talk about is the use of restrictive practices in relation to a care recipient must not be inconsistent with any rights and responsibilities of care recipients that are specified in the user rights principle. The Charter of Rights has been an incredibly important introduction into the aged care system, a recognition that older people have rights and they need to be part of any decision making process.

**Kyle Olsen:**

Well Geoff let’s pick up on that. How does the revised legislation reinforce the rights of aged care recipients?

**Geoff Rowe:**

Well by reinforcing the Charter of Aged Care Rights. I guess as an advocate over time I’ve often seen that older people are required to check in their rights when they check in to aged care and it’s part of that broader ageism that we as a society – when we look at older people we somehow or other decide that everyone has a cognitive impairment, that no one can make decisions. And so it’s really important that the legislation does actually reinforce that older people have rights but it also reinforces that they need to be part of that decision making process. Cognition or having capacity is not like pregnancy. Pregnancy you’re pregnant or you’re not pregnant. With cognition you can make a whole range of decisions. You might not be able to make complex decisions but you can make decisions that impact on yourself.

So again I would just reinforce as the legislation is that older people must be part of the decision making process. It’s not something that they pass on to their attorney or to a family member or to another staff person in the facility. Incredibly important that they are involved.

**Kyle Olsen:**

Absolutely. Thank you for that Geoff. Look we received a lot of pre-submitted questions about consent as it hasn’t always been sought in the past. How important is it for providers to understand their consent obligations?

**Geoff Rowe:**

Again another incredibly important point. Historically when someone’s seen to have an impairment we’ve often gone to a substitute decision maker. So we’ve decided that that person’s unable to make decisions. And in recent times I’m really pleased to be able to talk about how our views of consent are changing. We’re moving from having a substitute decision maker to informed consent. And so informed consent is about talking to the older person about what is going on in a way that they can understand so that they can make a decision that is informed, that they have the knowledge. The old saying knowledge is power. Very much. We all need information to make an informed decision. Older people are no different.

And in the recent vaccine rollout within the residential aged care system we’ve seen pressure on providers to use informed consent, so to involve the older person in that decision. So we’ve already got some experience in that space. There’s an opportunity now really for us to pick that up and to run forward again with information in a format too that an older person can understand. And we know that with dementia the last skill acquired is often the first skill lost. So there are a lot of older people in aged care who will need something in their own language to be able to understand. But as an aged care provider that’s something that we should be able to support that person with.

**Kyle Olsen:**

Thanks Geoff. Some really important points there. Now there’s obviously going to be a lot of confusion during this transitional time so how can an OPAN advocate support residents and their representatives to understand the changes but also to engage in discussions with their aged care provider about restraint alternatives?

**Geoff Rowe:**

Look an OPAN advocate generally provides three types of support. We provide support with individual advocacy, we provide support with information and we also provide support with education. So OPAN advocates are able to provide education sessions within aged care to help people better understand the legislation and the implications. In situations where someone believes that the new changes are not being implemented or that they are being required to undertake restrictive practices that aren’t in accordance with the new legislation then they’re welcome to call an aged care advocate who can explain what the current legislation requirements are but can also support them to raise their concerns with the aged care provider. We often talk about advocates giving the older person a voice and it’s making sure that the older person’s voice is heard.

The number for the aged care advocates is 1800 700 600 or you can access us online via opan.org.au.

**Kyle Olsen:**

Thank you. Thanks Geoff. Look as Geoff previously explained we now have legislation brought in where alternative approaches or strategies must be used before any restrictive practice is used. And in our Medication. It’s Your Choice series of webinars we discussed a number of alternative approaches including intergenerational care, pet therapy, reminiscence, music therapy, sensory support and environmental design. And just as a reminder if you would like to watch these webinars you’ll find them on our website opan.org.au/yourchoice.

But it’s important to note that as far as alternative approaches go it’s not a one size fits all scenario. The approach used must suit the person and their individual needs and wishes and not just assume that all older people think or act in a certain way.

Steve the cornerstone of this is a person-centred approach. Can you explain the importance of this and how it should be implemented in residential aged care facilities?

**Stephen MacFarlane:**

Sure. I guess Kyle to make the point first of all that a person-centred approach is this should not be news to any of our listeners. Many providers for the last couple of decades have prided themselves on providing a person-centred approach but the staff on the ground have trouble recognising what that actually means and how to implement it. I think you hit the nail on the head when you said that the heart of a person-centred approach is tailoring your care approach in whatever terms to the individual, to their likes and dislikes, rather than using an off the rack or a one size fits all approach. So the approach to care needs to take into account such things as personal dignity and respect, rights, an individual’s history, lifestyle, culture, likes and dislikes and so forth.

In relation to person care and behaviour management which I guess is what we’re talking about, we need to move beyond simply recognising a symptom such as agitation and taking a one size fits all approach to the treatment of that symptom. At the moment the default approach seems to be the prescription of a psychotropic for agitation. But by way of an analogy to explain how a person-centred approach might do it better, if I were to ask the audience to imagine you went to your doctor with the symptom of a cough you’d be outraged if the doctor noted the cough and simply sent you away with a prescription for a cough suppressant, because that might treat the symptom but it doesn’t take into account why you are coughing. It might stop the cough but you still might die of the underlying pneumonia.

It’s the same with agitation and behaviours. These behaviours are arising because a need is not being met or the person is distressed in some way. In response to any behaviour we should be asking why is this person behaving in this way at this time and then tailoring our response not to treat the symptom but to treat the cause of the symptom that underlies the behaviour. And I understand that there’s practical gaps in being able to implement a truly person-centred approach in residential aged care. The Royal Commission was very clear that staff are over‑stressed and too task focused which is why there’s recommendations around staffing numbers and staffing expertise, and also in dementia training for the aged care workforce. I think it's a shocking state of affairs currently where despite at least 50% of residents of aged care living with dementia that dementia behaviour management as a module remains optional within the standard aged care basic curriculum. That’s a disgrace and needs to change in order for us to do this person-centred approach.

**Kyle Olsen:**

So Steve am I right in saying that a person-centred approach should be put in place in order to prevent behaviours occurring rather than just waiting for the behaviours to occur and then trying to implement therapies in response to them?

**Stephen MacFarlane:**

Absolutely. The behaviours are in response to something whether that’s an unmet need in broad terms, it could be in response to boredom or over-stimulation or frequently as we find within DSA the presence of pain. So if you’re proactively taking your residents’ needs into account and trying to meet those needs prospectively you should be able to in the majority of cases prevent a behaviour from occurring rather than having to recognise their unmet need and then meet it once they’ve signalled their distress by the presence of a behaviour.

**Kyle Olsen:**

Thanks Steve. Lyn I’m going to move on to you now. For person-centred care to be effective aged care staff really need to get to know the person. Now can you share with us some practical examples of ways in which staff can do this?

**Lyn Robb:**

Thanks Kyle. I’m often asked to talk about person-centred care for people with dementia and that’s like asking about person-centred care for people with red hair or person-centred care for people with sore feet. What I would like to talk about is care for the person living with dementia. And in order to care for that person living with dementia I need to understand and know that person, in order to understand why that person is behaving in a certain way I need to know that person.

So I’m going to talk about George. And George is a person living with dementia and it would be important if I was going to care for George that I know about where he was born, who is George’s family, what did George do for a job, what did he like doing in his younger years and what has he enjoyed doing when he retired, what does he still like to do and what is important to him. And so I’m going to talk about myself as a nurse who has come into the Happy Valley Aged Care Home on night duty and I’ve got many residents to look after. And I’m getting a handover about those people. I don’t know them well. And I’m going to be caring for George and I’m told that George is in room 24. George is in a single room with his own ensuite. He didn’t eat much for tea. But the thing I really need to know is that about half past four or five o’clock in the morning George gets up and he walks around the care home and he bangs on the doors and the windows and he wants to get out, and when I ask him to go back to bed I’ll probably get a very agitated and aggressive man.

So I’m already thinking about the problems that I’m going to have as a nurse in that aged care home during the night with George and the problems that George is going to have. So wouldn’t it be good if I knew something more about George? Wouldn’t it be good if the care home had a life story about George? So it may well be that they do have a life story but I don’t have time to read it. So I could just be told five things. George worked as a farmer, he likes to wear work clothes, he barracks for Collingwood, he likes to go outside and he likes chocolate. So when George gets up at 4:30 or 5:00 I can help him to dress into his work clothes. I can give him his breakfast ready for his day on the farm. I can give him some things to do like clean his boots or I could open the door to the garden in the care home and let George walk outside. And that is the person-centred care that we’re looking for for George who lives with dementia.

**Kyle Olsen:**

I love the example Lyn. That’s fantastic. So just to follow up on that Lyn, as today I said we want to give as many practical ideas as possible to everyone watching, so from your experience on the ground, from visiting a number of aged care homes, can you share some more practical examples of how staff have implemented a person-centred approach?

**Lyn Robb:**

Yes. And I want to talk about simple things Kyle because it doesn’t have to be complex. And it is important to call the person living with dementia by their preferred name. We’ve all had conversations with people and you ask them to call you Lyn, not Lynette, and you think they’re listening and you think you’re important to that person, and the next day when they see me they call me Lynette. So I want to know that I’m going to be called by my preferred name. I want to know that the soap and the perfumes that I’ve used all through my life are going to be available for me. And so it is important to have those on hand.

The person living with dementia in the care home might like to talk about the photos of their family members. And often the staff are very pushed with time. We know that. But a simple one minute conversation about one of their family members in their room leads into less behaviours and less resistive behaviours and less need for medication. So listening to the person and talking about the things that you know as a carer because you’ve read the life story. Favourite foods, giving people things to do around the home. So it is accessing the knowledge of that person and utilising that in the care home.

**Kyle Olsen:**

Thank you for that. And also just while I’ve got you how should aged care residents and their representatives go about discussing alternative approaches with the provider?

**Lyn Robb:**

Sure. So the resident needs to be encouraged to talk about what is important to them. Always ask the resident why they’re behaving in a certain way. You get some very interesting stories when you ask those sort of questions. See if the care home has a life story and if not has a family member provide a life story of that person. And ask the person about things that happened earlier in their life and you’ll get lots of stories. Because we know that the long term memory is pretty much intact for quite some time for a person living with dementia.

**Kyle Olsen:**

Thanks Lyn. Steve I read an article you wrote where you said that at some point most people living with dementia will have behavioural and psychological symptoms and that the first line treatments for these symptoms are not drugs but behavioural and psychological interventions. Can you tell us more about how this could be applied in an aged care environment?

**Stephen MacFarlane:**

Sure. I think Kyle the numbers are that at least 95% of people living with dementia will have some form of behavioural symptoms throughout the course of their illness. So these symptoms really are ubiquitous and these recommendations about behavioural and psychological interventions being trialled first are not new or ground breaking. These have been internationally accepted consensus guidelines since at least the 1990s. It’s just we have fallen down in the implementation of them and we tend to pay lip service to them.

Often in Dementia Support Australia when we ask care staff what behavioural and psychological interventions they’ve tried they’ll say ‘We tried aromatherapy, we tried massage. It didn’t work so we’re prescribing an antipsychotic instead’. Again that gets back to a failure of a person-centred approach. There’s nothing magical that will suggest behavioural and psychological interventions will work if they are applied in a blind way without regard to the person’s individual triggers for behaviours and their individual unmet needs.

Until recently the evidence around the efficacy of many behavioural and psychological interventions has been lacking but with DSA having been in place for about four years now we recently published the outcomes of our behavioural and psychological interventions from around 6,000 patients over two years in Frontiers in Psychiatry, a journal in April this year. We were able to demonstrate a decrease in behaviours of between 60% and 70% using non-pharma strategies compared to an average effect size of a decrease in about 8% through the use of antipsychotic drugs for example. So we’re finally learning that these approaches work if applied correctly in a person-centred way and are much safer than the pharmacological approaches.

**Kyle Olsen:**

They’re incredible results. That’s amazing. The last 18 months have been a trying time for everyone but particularly for people in aged care and those living with dementia. They’ve been in very strict lockdowns where visitation has been restricted if not completely stopped. Now OPAN has received so many calls from worried relatives who have seen them become withdrawn, confused, frustrated, and in many instances have also seen a sharp cognitive decline or they’re demonstrating behavioural and psychological symptoms.

Lyn can you tell us about the Dementia Engagement Modelling Program that you’re leading and how it can help staff and residents during this time?

**Lyn Robb:**

Thanks Kyle. Yes. So the Dementia Engagement Modelling Program or DEMP is a program that was set up under the grief and trauma package specifically looking at the impact of COVID on aged care homes and their staff and their residents and the families. And so the dementia consultant with DEMP will go into the care home and work alongside the staff and residents every day for a period of two weeks modelling how we assess clients for activities to engage their interest, how we trial those activities and how we evaluate them. And the importance of this program is actually being seen. So rather than talking about how to engage people, rather than talking about what activities would be appropriate, rather than talking about how we utilise the life story, it is actually showing aged care staff and residents and families how we do it. And it is those conversations in the corridor about why we do things a certain way, why we ask the person living with dementia what they would like to do.

And an example very quickly would be that we saw Greg and he has become very withdrawn during this time. He is still trying to communicate with nurses who look like aliens in their full PPE, in their masks and in their shields. And he sits all day staring out his window. Now we know that George likes football so we put football gnomes in the garden outside his window along with some other plants and now Greg leaves his room and comes outside to check on the wellbeing of the gnomes. And in that time he’s talking to other people along his journey.

**Kyle Olsen:**

That’s great. If you would like more information about the Dementia Engagement Modelling Program we’ll put the details up on the screen for you right now. You can get it from dementia.com.au/services or of course you can always give them a call on 1800 699 799.

Steve we had the following question pre-submitted by one of our viewers. What do you suggest for residents living with dementia who are no longer able to engage in activities or conversations and don’t like being touched?

**Stephen MacFarlane:**

It’s a great question Kyle because it brings us back to this concept of person-centred care once again. I’d be strongly of the view that there is no one right answer to that question because for residents with dementia who don’t like to be touched there might be many different reasons why the particular person does not like to be touched. So you can’t give an answer that applies to everybody. People might not like to be touched because they have pain or they’re sensitive to movements or they get frightened by a sudden touch that isn’t pre-empted or flagged by the carer. So again trying to determine why the person doesn’t like to be touched is the first step to trying to develop an answer for that person.

Again I’d reflect back on the part of the question that related to their ability to engage. Even in advanced dementia people still have the capacity to engage at certain levels. And there’s a clear difference between actively engaging where the person is doing something in response to a stimulus and passively engaging. And we all passively or actively engage at various times of our day. Reading a book is an active activity. Listening to music, watching a film can be passive activities. Just because somebody’s lost the capacity to verbalise, to communicate verbally and to participate in a conversation doesn’t mean that that person cannot respond to being spoken to, to reassuring tones of voice, messages of love and support and so forth. So tailoring your approach to the degree of the person’s disability and asking why is that person particularly sensitive to touch would be the starting point to addressing that question.

**Kyle Olsen:**

Thanks Steve. We’re going to look at music therapy as an example of an alternative approach but obviously music therapy isn’t the answer for everybody. What’s the best way for aged care staff to know what therapies are suitable for each resident?

**Stephen MacFarlane:**

Well in terms of likes and dislikes I’m aware that when people enter aged care there’s usually a resident profile form that’s filled out where families are interviewed, the resident themselves is interviewed about their likes, dislikes, regular routines and so forth. And that resident profile document is intended to inform the care plan for the resident. Unfortunately after they’ve been filled out a lot of them seem to be filed and never referred to again. There’s no point in collecting this information if you don’t use it as a rich resource to develop your person-centred care. If the resident profile is not available then families are usually a great source of information if the person’s lost the ability to communicate their likes and dislikes themselves. A collateral source who knows the person well would be able to let you know which things are most likely to succeed. I wouldn’t use doll therapy for example in somebody who’s always hated babies. It’s doomed to fail. Tailor the therapy to the likes and dislikes.

**Kyle Olsen:**

Thanks Steve. Let’s look at how we can apply a person-centred approach to music therapy. Felicity it’s great to have you back on the panel. Last time we spoke we covered more of the theory and science behind music therapy and to be honest we got such great feedback from that session. It created a lot of interest and many of our aged care staff viewers asked for more information on how they could implement music therapy into their programs. So today we’d like to focus on the practicalities but also link in with what we’ve been discussing previously.

So just to recap for anyone who didn’t see our previous webinar with you can you give us a brief rundown on what music therapy is and how it can be used as an alternative approach to chemical restraint?

**Felicity Baker:**

Certainly Kyle. Well we know that music therapy is an allied health profession where credentialled music therapists use music purposefully and in a person-centred way to support wellbeing. So music therapists may practice with a variety of people with various health challenges ranging right through from premature babies in NICU, people with disabilities, in mental health, in neurorehabilitation and certainly working with people who are living with dementia. And it’s really important to note that music therapy isn’t entertainment. In music therapy the music is used intentionally, as I said in a person-centred way, with an end goal in mind.

So when we’re thinking about using music therapy as an alternative to chemical restraints we know that when people are confused and distressed as Stephen was pointing out before it can often be because of unmet needs. Well music has this capacity because it’s familiar and recognisable it can be calming and it can help to address these unmet needs. So that’s why it can be useful as an alternative to a chemical or even a physical restraint. It can help people to regulate their arousal when they become over aroused or over stimulated. They can become more connected and oriented to their surroundings. So any memories that are stimulated by music may lift their mood and they can become more lucid and even start to chat to those people around them when they might not have before. And even in some circumstances people with dementia may recognise their loved one as a result of the music orienting them to the here and now. This orienting response means they’ll be less confused and therefore less likely to need restraining of any kind because they’re starting to make more sense of their surroundings.

**Kyle Olsen:**

Thanks Felicity. Well we want to make this session as practical as possible for providers, aged care staff and home carers so let’s start off by talking about residential aged care. Now Felicity you must have been thrilled to read recommendation 38 in the final report from the Royal Commission into Aged Care Quality and Safety where Commissioner Briggs wrote that by 2024 every residential aged care facility should employ a music and/or art therapist.

**Felicity Baker:**

Yeah. We were absolutely delighted with the result of the Royal Commission’s report and their recommendations. And indeed the submission that I was leading with a team of music therapists in my group, we found that there was strong evidence and we reiterated that in our submission. And we really emphasised that music therapy whilst everyone can benefit from engagement in music therapy there are certain groups of people in residential care that it has particularly strong effect with and I’m going to talk about that perhaps a little bit later. But we know that there is evidence to suggest that those people with dementia who are more progressed are more responsive to music therapy. So this is one reason why residential aged care facilities should be really encouraged and want to engage a music therapist.

**Kyle Olsen:**

Okay. So how does a residential aged care facility start a music therapy program?

**Felicity Baker:**

Well now that we have this recommendation it should be a starting point for residential care home staff to be advocating to introduce a program well before it has to come in 2024. So music therapy is no more expensive than hiring an entertainer actually. For those of you who’ve hired one before it’s not that expensive. But it could actually be more cost effective because music therapists are actually trained to maximise residents’ participation levels. They’ve got special skills in that area which makes staff caring for them easier. So the nursing resources become more efficient as well.

So there are a number of different programs that could be relevant for your aged care home. For example there’s a group that I call the sunset group which is a specifically tailored program to support the needs of people with dementia who may be experiencing much more confusion and distress during the later hours of the day, a phenomenon that used to be known as sundowners although some people would no longer like to use that term. The music therapy program creates these music relational experiences, helping residents to regulate their arousal at this particular time of day to help reduce their sense of confusion, their sadness, their agitation and their distress.

And we’ve been looking at data and we know that there seems to be less PRN medication use when this is used because they are less distressed in the afternoon when they’re engaging in these music programs. There’s another one we’ve got called music identities program which really addresses that idea of dignity and choice by promoting personal and sociocultural identity and personhood. And so using music experiences our programs enable people to have what we call musically stimulated autobiographical recall to help them reminisce and remind them of their history which is a way of kind of reaffirming their identity.

And so if an aged care home wants to get in touch they can certainly get in touch with my company called Fab Musicare where I can help to facilitate recruiting a suitably qualified music therapist but also we outline family training programs and care staff training programs about how to use music in sensitive and strategic and intentional ways.

**Kyle Olsen:**

Thank you Felicity. Personally I find it incredibly interesting. Now you recently completed a residential aged care home study that explored the impact of music therapy on residents particularly those living with dementia. Can you tell us what you found as a result of the study?

**Felicity Baker:**

Yeah. So I’m really excited. We’ve just been wrapping up our analysis now and we’re in the write up and I’m very excited to be able to report that we were able to find that music interventions really did decrease levels of depression in people with dementia and also managed their neuropsychiatric symptoms, particularly the severity of them but also the distress that staff reported in response to that. And our randomised control trial recruited 318 participants until unfortunately the pandemic terminated our study a bit early. But one of our care homes was even involved in the COVID outbreak and we were able to capture some of the data from that place.

What we know is that despite that early termination of our study our results really show that the music interventions decreased depression and neuropsychiatric symptoms in people who were more progressed in their disease. The effect was much more pronounced in those people. And we also found that the interventions that were more oriented towards stronger emphasis on singing as being the musical element of the sessions also had a stronger effect which was very interesting for us.

**Kyle Olsen:**

So Felicity realistic though, a music therapist isn’t going to be on site and available 24/7 so how can staff who are there around the clock implement the principles of music therapy so residents can continue the benefits when the therapist isn’t there?

**Felicity Baker:**

Yeah. Absolutely. So the best way to support residents really in the absence of a music therapist is to have a music therapist come and train the carers in how to use music in the right way. Because again going back to that person-centred focus each resident will respond to different music and respond in their own unique way. So our music therapist can teach carers how to use music to attune to the resident’s state at any one moment.

And just to give you an example, a practical example, just imagine you’re a care home staff and you’re about to shower someone and they’re naked, they’re sitting on a shower chair, they’re confused, they don’t really know what’s happening. They’re probably cold as well. And the carer can sort of begin singing to them before they actually get them into the shower. So for example you might start singing ‘I’m going to wash that man right out of my hair’ or ‘Raindrops are falling on my head’ something like that that will orient them to the fact that there’s going to be water involved or washing, and that could be a way to kind of calm them down. Likewise Lyn mentioned before about the gentleman who was wandering around in the middle of the night. You could actually use music to sing to them to orient them that it’s nighttime and maybe they might want to stay in bed for a little bit longer. So you could sing things like ‘Goodnight sweetheart’ or even believe it or not – it might sound quite childish – but singing something like ‘Twinkle, twinkle little star’ because it’s familiar. Everybody knows this song and so it can be quite useful to orient them to the fact that it’s nighttime and maybe they might want to go back to bed.

**Kyle Olsen:**

Some great tips there Felicity. Now when it comes to making a personal playlist for someone – and this is applicable to whether it’s a person in a residential aged care facility or in home care – how do you know what music to use and what do you look for?

**Felicity Baker:**

Yeah. Great question. I think the first point is that families are often the people who will – well first of all you ask the person themselves. That’s the number one rule. Ask the person themselves what kind of music they like. But if they’re not able to communicate that then the next port of call is to go to family to find out, particularly a spouse or a sibling, and failing that an adult child. And we need to remember that we try to use music that supports reminiscence and things but sometimes music can also generate negative responses and we need to be mindful of that.

So just to give you an example a song that reminds a person of his or her spouse may lead to pleasant emotions one day as they recall pleasant memories that bring joy, but the next day it might lead to tears when they suddenly have moments of lucidity realising that their spouse is no longer with them. Of course as a family member or a care staff member you can’t predict this. No one will know how they’re going to respond on any one moment. But it’s okay because loss is part of life and as long as you’re there to support them in their loss it’s okay.

**Kyle Olsen:**

Thanks Felicity. Let’s move on to music therapy in a home care environment. If you’re a family carer or someone living with dementia there is an exciting opportunity that you may be interested in. The University of Melbourne is leading a huge international program called Homeside and they’re looking for people who are interested to take part from around the world. Now Felicity can you briefly explain to everybody what the program is, what it hopes to achieve and how someone interested would go about finding out more?

**Kyle Olsen:**

Yes. Thanks Kyle. Yes. Homeside is a study. It’s running in five countries. Australia’s leading it and it’s the largest clinical trial in music therapy in dementia that’s working with people in their own homes, so in the community. And it aims to support family carers to use music and reading in strategic ways to help reduce their isolation, increase their wellbeing, foster connections with loved ones and enhance the quality of life of families of people living with dementia.

And we’re really calling on carers and people with dementia to come and join our project. Everything’s done online via Zoom or Facetime so there’s no need to travel anywhere from your home. And it’s also Australia wide which is really fantastic because so many trials are often not accessible to people in regional or remote Australia.

[*Visual of slide with text saying ‘Homeside’, ‘Partnership in dementia care’, ‘homesidestudy.eu’, ‘(03) 9035 3057’, ‘homeside-australia@unimelb.edu.au’, ‘OPAN’, ‘Older Persons Advocacy Network’*]

If you’re happy to participate we have a website which I can see you’re going to put it up. Please register. And just remember that you might receive music and you might receive reading and you might receive standard care but it’s important for science that we demonstrate how music can be useful for people with dementia and their family members. But whatever happens, even if you don’t get what you want in our study, we give you whatever you want at the end as a thank you.

**Kyle Olsen:**

That sounds fantastic. Thank you very much for that Felicity. Look we’re going to move on now and have a look at some of the questions that you’ve sent through for our live Q&A. We are running a little bit short on time so if the panellists could give as succinct answers as possible that would be appreciated.

Steve the first one’s for you.

*Q: I’m a board member of a residential aged care facility and I’d like to reduce the number of residents who have chemical restraints. Our benchmark is higher than industry average. Staff have had training but there’s still no reduction in use. What could our board be doing or measuring in order to encourage staff to use alternative approaches? I want to get to zero chemical restraints but this is pushed back as not possible.*

**Stephen MacFarlane:**

If you’re after a succinct response to that Kyle the only gem I’ll give is that simply measuring it and publishing the results of your measurements and making those measurements visible to staff and GPs will probably have an effect in itself. In science it’s called the Hawthorne effect, the simple fact of observing something causes the outcome to be changed by virtue of being observed. So publish your findings and make the staff and your GPs aware of them.

**Kyle Olsen:**

Thank you Steve. Geoff a question for you.

*Q: Should the informed consent be written or verbal too?*

**Geoff Rowe:**

Look informed consent at the end of the day, written is always good, but verbal works as well. I think you want a record that the conversation has occurred and what the older person has said.

**Kyle Olsen:**

Thank you very much. A question for Lyn. This came through from Val.

*Q: All medications prescribed or available need to be on a person’s record especially in care, so if the person is having an outburst or self-harm that a medication previously prescribed is on the current medication list. How can this be better implemented?*

**Lyn Robb:**

So all the medications are there and we’re saying that the medication chart is confusing I presume?

**Kyle Olsen:**

Yes.

**Lyn Robb:**

Yes. So I think they can be. When medications are changed often it’s just a line drawn through them and it’s a bit unclear as to what the actual dose is. Often in care homes it’s the care staff not the nurses that are giving the medication and I do think that there need to be simpler medication charts so that we can really zero in on what’s being given and being given appropriately. I hope that answered the question.

**Kyle Olsen:**

Geoff I’ve got a question for you from Val.

*Q: When do guardians’ rights overrule a person’s rights where the medics are recommending a treatment approach that the person is resisting?*

**Geoff Rowe:**

That’s a very technical question isn’t it Val? I feel like I need to consult a lawyer to give you a legal answer.

The primary consideration is the individual ultimately has rights and choice themselves and should be in a position to make those. We certainly have a history of supporting people to go back to the Civil and Administrative Tribunal where there is significant conflict between a guardian’s view and the view of the older person and that may be a course of action that we want to go down. But certainly you can use an advocate to help the older person to communicate with their guardian about what their wishes are and how they want to proceed. So give us a call.

**Kyle Olsen:**

Thank you very much. 1800 700 600. Lyn a question for you.

*Q: How do we implement these strategies with dangerously understaffed facilities and hospitals?*

**Lyn Robb:**

Sure. So with the DEMP program we’re looking at activities that are meaningful but are easy to set up and that the person can do pretty much independently. So we’re not going to come into your home and say ‘I think you should sit with Mary for six hours a day and then everything will be fine’. Because you actually won’t have us in the next day. So we do need to look for simple activities with minimal set up.

**Kyle Olsen:**

Thank you very much. Thank you. Steve I have a question for you.

*Q: Is there a decision pathway for clinicians to follow for the level of tolerance before pharmaceuticals are used?*

**Stephen MacFarlane:**

I think the key question is to determine what’s reasonable to try in the circumstances before you resort to psychotropics. The revised Aged Care Principles require that clinical care reflect best practice and aim to optimise the person’s wellbeing. If faced with a choice between prescribing something and involving a service such as DSA if the staff in the facility don’t have the skills and expertise to assess and implement, then a referral to DSA would probably in most circumstances be feasible, reasonable and least restrictive than prescribing. So encouraging care staff to refer not necessarily to DSA but there’s other people who play in this area as well, rather than giving into the urge to prescribe when faced with a problem. And unfortunately that’s all that many doctors know how to do is prescribe.

**Kyle Olsen:**

Thank you very much. Felicity last question for you.

*Q: How do we move music therapy practice from a nice thing to do to an essential and first line approach to care?*

**Felicity Baker:**

Well I think the best way to do it is to really start to educate staff about what music therapy potential has. Because I think sometimes there are many people who just make an assumption that just because someone likes music that that means that music therapy will be good for them. I think it’s often more about identifying what the needs are and whether music could be used as an alternative to chemical restraints. Yeah. I just think it’s about educating staff about its potential really.

**Kyle Olsen:**

Thank you. Thank you Felicity. Look that’s all we have time for today. We would like to thank our panel members for their time and expertise. Steve MacFarlane, Lyn Robb, Felicity Baker and Geoff Rowe. Thank you to all of you.

We’d also like to thank you for joining us and for the questions you sent through. But please remember you can always talk to one of OPAN’s professional aged care advocates by calling 1800 700 600. Today’s webinar will be on OPAN’s website in the coming days along with all of our past ones. So if you missed it or you know someone who should watch it then please let them know as we’d love to be able to help them.

Our next webinar is next Thursday, July the 8th at 11:00am Australian Eastern Standard time and we’ll be discussing a very important topic as we’ll be explaining how every single one of you can become an everyday advocate. And also we have the follow up webinar to this one, the second in the series of alternative approaches to chemical restraint. We’ll be looking at specifically for people living with dementia. It will be a practical guide. And that’s on Tuesday, the 13th of July.

Until then everybody stay well, stay connected, most importantly look after each other. Goodbye.

§(Music Playing)§

[*Visual of slide with text saying ‘This webinar is in memory of Claire Levisohn’, ‘1968 – 2021’, ‘a valued member of the OPAN team and an absolutely awesome everyday advocate for older Australians’, ‘OPAN’, ‘Older Persons Advocacy Network’, with an image of Claire to the left side of slide*]

**Speaker:**

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[*Visual of slide with text saying ‘OPAN’, ‘Older Persons Advocacy Network’, ‘1800 700 600’, ‘opan.org.au’*]

[*Closing visual of slide with text saying ‘production by create.love’, ‘www.create.love’*]

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