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THE CASE FOR LEISURE AND LIFESTYLE IN RESIDENTIAL AGED CARE

By Graeme Pope - 24 May 2020

INTRODUCTION

This Royal Commission into Aged Care is a welcome government initiative. I am grateful for this opportunity to advocate for change in an industry I am passionate about, based on my own first-hand, Australia-wide experience of the sector and how we approach the care of our elders.

This submission is presented in five parts as outlined below.

Throughout the submission any reference to 'Leisure and Lifestyle' encompasses all facets of this role, variously referred to as Recreational Activities, Diversional Therapy, Activities Coordinators and so on.

Input from others referenced in the body of the document, and supplementary case studies, are presented in blue text.

- PART 1 THE CASE FOR LEISURE AND LIFESTYLE STAFF IN RESIDENTIAL AGED CARE

The heart of my presentation is centred on PART 1 which addresses the many challenges faced in aged care, with a particular focus on the Leisure and Lifestyle role.

Here, I advocate on behalf of those employed as Leisure and Lifestyle staff in residential aged care. I find myself passionately engaged with the people who facilitate the Leisure and Lifestyle programmes for our elders, and I believe their role is central to meeting human needs beyond the 'clinical' in residential care. After all, what is the point of waking each day if not to engage in our chosen activities of interest?

I will examine the importance of this role and consider the challenges those working in this field face.

- PART 2 THE SOLUTION

In PART 2, I present what I believe would be an effective solution to the issues I identify, in terms of valuing and expanding the professional Leisure and Lifestyle workforce through Human Factors, or Non-Technical Skills (NTS) Training

It is my belief that legislating behaviour never works but educating people does.

The NTS training I propose would aim to transform the hierarchical culture within Residential Aged Care, to one of a strong community of valued and supported members who are focused on providing the best possible care to our elders.

Here I suggest the implementation of a universal compulsory training programme based on the successful aviation industry Human Factors – Non-Technical Skills model, for all working in aged care. This would include not only the nursing and care teams but everyone, from Board Members to hospitality staff.

- PART 3 THE IMPORTANCE OF MUSIC IN AGED CARE

PART 3 is supplementary information where I explore the value of age-appropriate music in residential care. It explains my involvement with the aged care industry and includes several case studies. Although I could fill a book with case studies, just a few appear in this paper to provide a glimpse of 'life at the coalface' in this industry, from my perspective.

Despite knowledge gained from research, endless anecdotal evidence, and the recent spate of media exposure this topic has received, **music in general, is still undervalued and therefore underutilised in the aged care environment.**

Retired from a 40-year career in commercial aviation I never imagined I would find myself involved in the aged care industry, but now in my retirement years, I play out a unique role creating music-based resources that support the work of care-givers engaged in facilitating Leisure and Lifestyle activities programmes.

Through this association with music, my journey in aged care has led to my visiting over 2000 nursing homes, residential aged care and retirement facilities, where I have met and talked with residents, carers, therapists, managers and Activity and Lifestyle Coordinators and have learnt a great deal about their workplace needs. During these visits I have witnessed a huge variation in terms of the quality of care and levels of engagement with the elderly living in residential care.

- PART 4 IN CONCLUSION

In PART 4, I present a brief summary of the challenges as I see them, and my recommendations for change, based on personal experiences during many years of dealing with the aged care industry Australia-wide.

- PART 5 PROFESSIONALS I RECOMMEND

PART 5 consists of the bios of professionals in various fields associated with aged care who I have had the privilege of meeting along the way. They could, if not already, be of assistance to the Royal Commissioners in formulating their final recommendations.

MY SUBMISSION DRAWS ON:

1. Personal experience gained through visiting and interacting with management and staff in residential aged care facilities across Australia, as a producer of age-appropriate music-based resources, designed to support the work of care givers engaged in Leisure and Lifestyle roles in aged care.

2. Knowledge gained during the completion of the Dementia Training Australia course: 'Recognising, Diagnosing and Managing Dementia in General Practice', November 2018.

3. Over 30 years' experience in Human Factors Training in commercial aviation, during which time I served as a facilitator.

4. The personal experience of having parents from both sides of our family who lived their final years in aged care facilities.

OBSERVATIONS WHILE VISITING AGED CARE FACILITIES:

Broadly speaking, I have found the facilities I visit fall into three basic categories:

1. A home with committed caring staff, who bend over backwards to find ways to improve the quality of care they provide. Some do this under varying degrees of adverse organisational and administrative circumstances. In this scenario, management and staff are generally dedicated people who work well together as a team, to engage with their residents, and who are constantly seeking better ways to manage their care and meet their needs and preferences.

2. The next, is an authoritarian regime, generally controlled by a hierarchical management structure that is rigid and resistant to change. They are not even looking for new ideas, and cling to an inherent clinical approach to residential care.

3. The final, is so toxic I wouldn't put my dog in there. The smells, the attitude of the staff, the décor and lack of stimulus for residents are all appalling. Fortunately, this group is relatively rare, nonetheless they should not exist at all.

As an interesting aside, something else I have found during my travels, is the variation in culture in the different areas, towns and even states. Rural NSW would be my favourite area, best city would be Adelaide. I thought Newcastle was a hard nut to crack until I got to Perth.

PART 1 THE CASE FOR LEISURE AND LIFESTYLE STAFF

The role of the Leisure and Lifestyle staff in residential care is core to meeting the spiritual, cultural, social, emotional, leisure and recreational needs and preferences of our elders in care; all of which are essential for their well-being and quality of life.

This is a role in need of industry-wide recognition as a profession of highly trained individuals, who are integral, respected members of the care team.

Lifestyle staff should have a say in how their role is shaped and it should be recognized that, as with any role, positive outcomes are best achieved when supported by appropriate training and funding.

IDENTIFYING THE ISSUES

I have identified many issues impacting the Leisure and Lifestyle role in the aged care sector based on my experiences when visiting facilities. These issues are best summed up by the words: untrained; under-resourced; and unsupported.

The following sub-points were added by Linda Hoogenboom, an experienced Diversional Therapist who expanded on these three points.

It is vital that these issues are addressed and remediated once and for all, so we can provide our elders in care with the best possible quality of life

1. UNTRAINED

Many staff are not adequately trained in designing, implementing, and evaluating quality Lifestyle programmes, and are unfamiliar with the culture of the elders in their care.

1.1. Training is still not uniform, and many trainees are deemed competent at a certificate II or III level even when they do not have the basic talent and skill-set required, such as: empathy, creativity, patience, emotional intelligence, understanding of disease process, leisure education, etc.

1.2. Many managers and senior staff think anyone can do the job, so unqualified people are often thrown into roles they are not prepared for. I have seen unqualified people with little experience in dementia, working in Secure Dementia units as recreational staff and finding themselves unable to deliver a programme suitable to the needs and abilities of the residents. This caused undue stress on the staff member and distress for the residents. Often many of these workers leave the industry because of this.

1.3. Untrained also means they are not knowledgeable regarding the culture of the residents and unable to spark appropriate memories for them. Many are immigrants who do not have a good understanding of Australian or other cultures, history, needs and practices.

1.4. Untrained means the staff member is also unknowledgeable in the health and cognitive limitations of many living in facilities and are unable to deal effectively with the challenges these issues bring.

1.5. Also, untrained staff often do not recognise good or appropriate resources, so their residents miss out and can be put in jeopardy by unsafe practices. Alternatively, they do

not use resources appropriately, and can put clients at risk by inadvertently triggering negative feelings and memories.

2. UNDER-RESOURCED

The budget-driven nature of aged care, as opposed to the person centered ideal, results in decisions re the purchasing of valuable resources for Leisure and Lifestyle programmes, resting with higher management, rather than being entrusted to the staff at the coal face who are running the programmes. As there is no direct funding for lifestyle programmes through the Aged Care Funding model, most organisations allocate minimal funding for anything other than clinical care needs.

2.1. Recreation is always highlighted in the marketing material of residential aged care organisations as it is a drawcard, however in reality, minimal resources are allocated to make it happen.

2.2. Many Leisure and Lifestyle staff are forced to fundraise to purchase resources. Resources are therefore limited to funds available and these usually fall short of the need. No-one else in a home is asked to fundraise for their essential tools and materials. This suggests that the profession is unappreciated and not taken seriously. Quality resources equate to quality programmes, professionalism and pride in work.

2.3. Many staff spend hours of their own time making or sourcing activities. They often use their own resources i.e. car, internet connection, craft materials etc. and this cost is never recovered. Also, handmade can often look unprofessional and even childish.

2.4. Working out of hours to get work done coupled with a heavy workload has caused many recreation staff to crash and burn.

2.5. Many buy their own resources to use, causing financial stress on people who are already underpaid for what they do.

2.6. Handmade activities may have been accepted by the 'Silent Generation', but this does not mean they do not deserve better. They fought, sacrificed, and worked hard to make this country and our lives what they are today. They should be shown the greatest respect by offering them the best resources available for their use. Today's Baby Boomers will be expecting a higher standard than this.

2.7. Ratios of recreation staff to residents is non-existent, meaning it is possible for one recreation staff member to be faced with facilitating an activity for 20 or more people on their own, with only a call bell available if they need help. This becomes a baby-sitting event rather than a meaningful activity and, considering these people are frail and suffering from dementia, the result can be chaotic, unfulfilling, unsuccessful, and stressful for the Recreation person.

I met one lady who was not qualified but had been given the job of Activity Leader for a secure unit of 15-20 people. When I met her, she was incredibly stressed as she just didn't know what to do with these people or how to cope with their behaviours. She also felt she had to entertain all of them all the time and was discouraged because that was not working. She breathed a sigh of relief when I told her (she had no experience to draw on) her expectation was impossible and would only lead to burnout if she continued. We came up with some other strategies I had learned and when I last checked she was doing much better.

2.8. Many organisations use volunteers to help, which is meritorious but when you are dealing with some of the behaviours associated with dementia, many volunteers do not understand, due to a lack of training. It also often creates more stress and workload

pressure for the staff who must deal with or supervise the volunteers, who often have their own agenda for being there. Staff can also end up managing their behaviours.

2.9. Understaffing is a risk to health and safety for both the staff member and the residents because there are not enough eyes and hands available to help or monitor. I still see and hear of many recreation people being asked to take residents out on their own in the van. It is clearly unsafe to be driving and trying to monitor residents in the back.

3. UNSUPPORTED

The hierarchy of management and staff in aged care facilities is often one of dominance and subordination, without due regard to the valuable experience, knowledge, opinions and needs of the staff working directly with the older people. It often leads to bullying and the loss of knowledgeable and productive staff from the industry. **High staff turnover is an indicator of this**.

Being unsupported:

3.1. Leads to bullying that can cause many to leave the industry; however, this is often done quietly with no recourse.

3.2. Often means those less knowledgeable about recreation call the shots and demand programmes they think are appropriate. I still see many managers who want to see craft activities and the results displayed because it looks good, but many elderly are unable to engage in this, nor are they even interested. With little help available, it is a nightmare for a recreation person to try and deliver such an activity on their own, but of course, the managers want to see the big events at their facilities as they look good and act as a drawcard.

3.3. Often results in the recreation person being a lone operator in the facility with no assistance from other departments. For example, as the Recreation person, I have been asked to wash my own dishes, shop for the food for the event, take people to the toilet during an activity (which makes the activity fall over), wash the van and take it for its service, feed people, buy gifts, take people to appointments and generally, anything else no one wants to do. There is no teamwork, just 'not my job'. All the while the focus for being there, which is to engage people in meaningful activities, is diluted by menial tasks.

3.4. Creates an atmosphere of resentment towards the recreation staff, as they are seen as just 'playing', and there is no understanding of the fact that every activity, and often every move within an activity, is designed with purpose to benefit the people there. Instead, it is seen as interfering with the structured clinical and personal care regime of the facility.

3.5. Means that many staff burn out or lose interest and hope in their job, and leave, or worse still, stay and become a burden to the facility, as they do not care anymore.

UNDERSTANDING THE GENESIS OF AGED CARE

Born in 1948, when I was young, aged care as we know it today did not exist. I had a grandmother who suffered with Alzheimer's and, if family had not looked after her, the only place for her would have been a hospital or asylum, which would have been cruel.

As society changed, and with people living longer due to advances in medical science, the government was faced with the challenge of providing care for an ageing population. Politicians, knowing little or nothing about caring for the aged, sought to consult with the obvious: the medical and hospital fraternity. The subsequent government funding model for the aged care sector was

purely ‘clinical’. This resulted in the aged care industry morphing into the ‘soft-hospital’ culture it is struggling to emerge from today.

Granted the aged-in-care are people with special needs to varying degrees, despite this, we should never lose sight of their spiritual needs; their sense of belonging; happiness and well-being; their sense of purpose and meaning, no matter how old or infirm they may be.

Recognising the shortfall in this clinical approach to care, the role of Leisure and Lifestyle emerged with varying job descriptions, to address these needs.

Nurses are an integral part of aged care; however, their rules of engagement are remnant of the ‘rise and slide of union influence’ era, over past decades. The Leisure and Lifestyle role, being a relatively modern-day profession, had its beginnings during the era of ruthless economic efficiency, where union powers were considerably weakened by government and industry looked upon people as costs to be reduced or eliminated entirely. Consequently, those fulfilling this role lack industry-wide representation, that would otherwise formulate acceptable terms of engagement and clearly define their role.

The Leisure and Lifestyle position was born out of regulatory requirements aimed at addressing elder care needs, as it became evident the ‘soft-hospital’ approach fell short. Today, the mere variety of perceptions as to how the Leisure and Lifestyle role should play out, held by management, other staff and even Leisure and Lifestyle employees themselves, has resulted in a profession that appears somewhat fragmented, disjointed and disconnected from the aged care team who often do not consider Lifestyle as valued and respected colleagues.

Currently there are a range of roles in the aged care industry which are there to pay lip service to standards, for accreditation purposes. These roles are given titles such as Diversional Therapist, Lifestyle Coordinator, Activity Coordinator, Recreation Officer, Recreation Manager and so on, and are filled by people ranging from trained Diversional Therapists and Lifestyle trained staff, through to those with no formal training in this area.

THE UNDERLYING CHALLENGE

The underlying challenge for those fulfilling a Leisure and Lifestyle role is that the government does not consider the importance of this role in the overall residential care plan. The flow-on from this, is that many managers often treat the position as a lesser role or perceive it as an unnecessary added expense. In the past Leisure and Lifestyle was supported by an Aged Care Funding source which no longer exists. Staff are generally poorly paid, and in many cases, they lack adequate training. Often, they are employed for nothing less than to meet a regulatory requirement; a mere tick-in-the-box exercise.

This management perception of Leisure and Lifestyle often limits the job description to one of entertainment and busy activities. A successful lifestyle programme should not be judged by the number of excursions conducted, or the inclusion of visiting musicians. People need engagement, not entertainment. I am not suggesting for a minute that we do away with entertainment. What I am suggesting is **activities and entertainment with meaningful engagement.**

In too many cases, those engaged in the role of Leisure and Lifestyle lack the respect of managers and other care givers. Often arms-length from the work they do, they have little understanding of what the role entails; they are often perceived as ‘babysitters’ or ‘game organisers’; a perception which contributes to the understaffing and lack of funding in the right areas.

The role of Leisure and Lifestyle needs industry-wide recognition as a cohort of highly trained individuals who are respected members of the care team. They should have a say in how their role is

shaped and expect to be supported by appropriate training and funding in order to achieve desirable and positive outcomes.

In summary, the Leisure and Lifestyle role needs:

1. Industry-wide recognition as a profession of highly trained individuals who are respected members of the care team; a role central to meeting needs beyond 'clinical'.
2. A job description with clearly defined boundaries and input into the scope of the role.
3. To be supported by appropriate training and funding. As with all roles, positive outcomes are best achieved when appropriate training and funding are provided.
4. A realistic staff to client ratio.
5. Association representation with a title that clearly defines the roles played out in Leisure and Lifestyle as one professional body.

AN INDUSTRY FOCUSED ON PROFITS

The aged care industry has come a long way from the early days of horrible urine-scented places, to that which is on offer today. Vast improvements have been made in the provision of quality accommodation for our elderly. At least we seem to be getting that part right.

As the aged care industry consolidates through takeovers by larger companies, in too many cases it is becoming a big business run by well-educated academics, trained in business management and commerce with, sadly, little or no training in aged care and no understanding of Lifestyle staffing requirements. Hence, at the 'coalface', it remains effectively poverty stricken.

In the past Leisure and Lifestyle programme funding was supported by the Residential Classification Scale, through questions 15 and 19, however since the introduction of the Aged Care Funding Instrument there has been no direct funding for these programs, nor any requirement for the employment of the expert staff essential for effective programme implementation. Support for this most important area of care has **gone backwards over the past years, as the industry has withdrawn support for anything that does not provide direct funding**. This trend must be reversed as it is impeding on quality outcomes in residential care.

Three of the team, who work with me to create resources to support the Leisure and Lifestyle role, are highly qualified and experienced Diversional Therapists. Their bios can be reviewed in Part 5 of this paper.

To date, only one remained in her role until she retired last August (2019). She was a Lifestyle Coordinator with four experienced lifestyle staff working under her and they were privileged to enjoy an ideal style of management, supportive of Lifestyle, to the point where they were adequately staffed and never refused a request for the resources they required to support their role.

One has had many job changes because of the mounting pressures and high expectations of her role, in facilities that were understaffed and underfinanced. She was smart enough to leave the jobs before burning out. Coming from a nursing background, she recognised the signs.

The other left the role altogether after the organisation employed a bone-crushing manager who stripped the Lifestyle budget completely.

I'm sure any of these ladies would be prepared to discuss their experience in aged care if the Commissioners so desired.

I have watched great people working in Lifestyle leave because of overwhelming pressure from management. Particularly over the past decade, as funding has progressively been withdrawn from this sector, many disillusioned and frustrated staff have left the role and even left the industry altogether. This trend has caused a huge loss of highly qualified and experienced people as they have been forced out of the industry. That should never happen.

Leisure and Lifestyle teams were once led by highly qualified Diversional Therapists and consisted of experienced Lifestyle staff; whose roles were supported by an appropriate funding model. Today, budgets are administered by academics or people with qualifications and background experience, which is unrelated to the Leisure and Lifestyle department they head. Although their position may fulfil a regulatory requirement, **they effectively filter what is available to the Recreation staff** based on their own judgement, prejudices, interpretations, and instructions from the top, which results in a relatively unsupported, dysfunctional and poverty-stricken Leisure and Lifestyle sector.

Aged care organisations will spend millions of dollars on attractive facilities, furbishing, technology, and medication. They also spend thousands of dollars on media and advertising to market the service they provide, yet there is a reluctance to spend a few extra dollars on resources designed to support the role of Leisure and Lifestyle, which is aimed at improving quality of life for the elderly in their care. Many organisations tend to have a minimalist attitude towards funding anything not directly driving profits.

Aged care homes provide a budget for clinical supplies, continence pads and food, but when it comes to Leisure and Lifestyle, there is relatively little funding available outside of basic care. **Many Lifestyle and Activities Coordinators end up purchasing resources from their personal income or seek external funding**. They have enough to do without having to get involved with fundraising activities to purchase the resources they require to support the work they do.

Continually raising standards without providing the tools needed to help them achieve those standards, places unfair demands on the lives of those fulfilling a Leisure and Lifestyle role.

Where it exists, the practice of bonuses for managers who come in under budget should be abolished.

MUSIC AS A TOOL IN LEISURE AND LIFESTYLE PROGRAMMES

As a producer of age-appropriate music, I have found music in the aged care environment is generally undervalued and therefore underutilised.

Age-appropriate music can have a significant, positive impact on quality of life for our elders in care. This is particularly pertinent when we consider the well-documented, frightening statistics around the numbers of permanent aged care residents in Australia who have been diagnosed as suffering from depression.

Most when entering care, only have their memories left. Exposure to the music they know well from their early years, aids them in reliving those memories.

Age-appropriate music is a recognised therapy that helps lift mood, calm anxiety, and distract the elderly from their many frustrations and worries. Music gives them a much-needed mental break from everything they must deal with. Driven by this knowledge I have spent the past sixteen years spreading the word about the value of music in aged care, particularly in dementia care.

I have often witnessed inappropriate music being utilised in aged care settings. (Case study 07 page 36)

Based on my experiences when visiting facilities, I have found:

1. Many staff are unfamiliar with the type of music with which aged care residents are able to engage.

2. The budget-driven nature of aged care, as opposed to the person-centred ideal, results in decisions re purchasing of valuable resources not being entrusted to the staff at the coal face, who are running the programmes, but with a manager, or other academically qualified person.

3. The hierarchy of the management and staff in aged care facilities is often one of dominance and subordination; without due regard to the valuable experience, knowledge, opinions and needs of the staff who work directly with the residents.

In too many cases, the aged care industry barely recognises the value of Leisure and Lifestyle, let alone the value of music in the care environment. Disappointed staff are told they have plenty of music to work with, with no regard to the appropriateness of the selection and whether or not it is music that evokes a positive response in the elderly.

Budget driven managers, such as these, are not concerned with how much of their own time conscientious staff are devoting to researching and sourcing music that may be of some relevance to their residents, or the fact that many are purchasing resources from their own money.

An extensive research study on 'The Importance of Music to Seniors' was conducted by the University of Prince Edward Island in Charlottetown, Canada in 2002. The study concluded with overwhelming evidence supporting the importance of music to seniors. This is something we look at in more depth in Part 3 of this paper.

MANAGEMENT RESPONSE

Many Lifestyle staff I meet are under-supported by their management. The notes I make following a visit reveal this. Many managers don't see a need to allocate funds beyond a concept of 'doing things'. Many Leisure and Lifestyle staff are allocated meagre monthly budgets, some as low as $50 a month.

In general, the best managers I come across are those from a Leisure and Lifestyle background. Most of them really get it when I show them the resources. They take them all. They express their gratitude towards my initiative in creating such quality resources. I am usually in and out in 10 to 15 minutes. Ideally, that is how it should be. Sadly, managers like these are few and far between.

The next best, are those who have had experience running a business of their own. They understand the costs and pressures associated with running a small business and producing quality resources to the high standard that we do. They know how to make decisions based on a global overview of the business. They know where to spend money to save money.

Then there are those who tend to micromanage their budgets, and everyone and everything else for that matter. In the real world of business, when people follow this type of approach to management, their business generally fails.

It seems apparent to me that many managers are so preoccupied with balancing their budgets and their administrative duties, they miss the whole point of how a quality program using appropriate music, can impact on quality of life for their residents. Music can relieve the dreadful boredom people often have to cope with when living in residential aged care.

Appropriate music also eases the workload for care staff, as those in their care while away many hours each day reliving happy memories through exposure to music, specific to their lived experiences.

Funding is desperately needed to provide for quality of life beyond basic care needs. Beyond the budget constraints there are actual people, whose worth is being impacted by this neglect.

CHALLENGES FACED IN LEISURE AND LIFESTYLE

During my travels I have met some amazing people working in Leisure and Lifestyle, for whom I have the utmost respect. Their dedication and commitment to their work is exemplary. Many of them, while highly qualified and experienced, are compelled by passion upon recognising the need in this area and have sacrificed pay and job status to take on this role. I have four of them working with me to put our music resources together.

To illustrate my point, I have included below, a letter I received from a Lifestyle Coordinator who is as passionate about the need for change as I am. Her name is Carol and she has given me permission to print her letter complete with name and contact details. However, for the sake of this written submission, I have redacted her family name and contact details. I am more than happy however, to provide them to Commission representatives upon request, if they wish to further discuss the content in this letter with her.

Email received Monday 23rd July 2018

Good Morning Graeme,

It was so refreshing to speak with you on Friday. It is so good to know we are not alone in our concerns about the care of our elders.

Your paper presentation sounds very interesting. I welcome your invitation to make a comment for it. Please find my thoughts below.

“My 16+ years career in the aged care industry has been some of the most rewarding work I have ever done. The care of our elders, people that have worked so very hard to build this country and to provide for their own families, is such important work to do.

I have always been passionate about supporting our elders to live their best life. Even as the grip of Dementia, immobility, or poor health, tightens on some of the elders in my care, I am compelled to support them to do as much as they possibly can for themselves, in order to help them maintain whatever dignity is possible.

But now…I find myself looking to leave the industry.

I am a Lifestyle Coordinator. I oversee an ever-shrinking team of dedicated lifestyle assistants and volunteers. As I see it, Lifestyle is not recognized, by government or by management, as necessary to the care provided for our elders. We are seen more as “babysitters” and “party planners” than as facilitators of meaningful engagement.

I have worked at two residential care homes in the last four years, one with 150 beds and one with 124 beds. The first one cut the Lifestyle department from a team of eight, down to four, before ultimately eliminating the department altogether and outsourcing the Lifestyle program.

My current workplace has, just this year, reduced the lifestyle shifts from 9am – 4pm, down to 1 – 5 pm, Monday to Saturday. This means that there are no Lifestyle staff on duty in the mornings, the time that many of our elders are most active. We now rely on volunteers to do what we once paid

Cert IV qualified employees to do. My own hours as Coordinator, have remained the same, however, my workload has increased by more than double, as I have to support volunteers or conduct activities when there are no volunteers available.

My mission as an aged care employee, has always been to make the home I work in a place that I would be happy to allow my parents to live in or one that I, personally, would be happy to live in.

I am defeated.

In a world that might be better than it is now, carers would be highly trained and respected members of the care team. Lifestyle staff would be engaging elders in truly meaningful activity. And our elders would be enjoying their time in the aged care home."

Please feel free, Graeme, to edit for brevity, if you wish. This particular "soapbox" is one that I can sometimes be quite long-winded about.

Kind Regards,

Carol

Carol is not alone in her predicament, as many I meet share her sentiment. These people are 'salt of the earth' people, passionate about the quality of care they provide, despite the lack of adequate support they receive. In an ideal aged care industry, we should be embracing and supporting people like them, not treading on them, and pushing them away. Their resilience is admirable when you consider all the negativity a broken system can dole out to them.

The introduction of new standards, the myriad of training courses on offer and recent media coverage, all acknowledge the need for change. But this begs the question, is this really working?

DEFINING A HOME OR AN INSTITUTION

There is something about us humans when we create institutions to meet human needs, if we are not mindful, we can tend to institutionalise the life out of life itself. It is so easy to get caught up in our own self-interest; self-importance; vested interests; positions and job status; that while playing the power games that go with these things, the very purpose of caring for our elderly can often pale into the background. Where I come across this, I often wonder if these people have forgotten what they are there for.

Some structure is necessary of course, to maintain a semblance of order, but this must never become a mask that shields us from meaningful connection with the people entrusted to our care. When the human element, coupled with meaningful connection, is replaced by rigid structure, no matter how much lip service we pay to 'their home' and 'person-centred care', the reality is, their home is an institution.

People in care are not the subjects of a business, nor are they objects of our programmes. They do not need a life full of activities and entertainment void of human connection. They are people who crave love, meaningful engagement, and purpose, like the rest of us. We must never lose sight of that.

THE WORKPLACE ENVIRONMENT

Today, at an industry regulator level, there is a lot of focus on meeting client needs, as reflected in the new standards. But this begs the question, what about the happiness and well-being of those

administering the care being conducted? Should new standards also embrace the needs of those performing the roles in the workplace environment? Are staff at all levels treated with the dignity and respect they deserve? Is the workplace environment a happy one? A toxic work environment will bring down the team and weaken morale with a subsequent flow-on effect for care outcomes.

This is where I see a change in industry culture is needed, and I believe it starts with an examination of the current management hierarchical structure and its impact at all levels.

The idea of putting more legislation in place or conducting more rigorous checks on people will not fix the problem. **Legislating behaviour rarely works; educating people does**.

PART 2 THE SOLUTION

WILL REGULATORY CHANGES ALONE WORK?

The aged care industry is regulated by a body that sets the standards required at all levels of care. Facilities undergo periodic inspections to ensure they meet these standards.

The underlying problem with this regulation-compliance approach is, without industry-wide training to a properly accredited and standardised qualification, the interpretation of standards and how they are implemented and administered can be quite diverse.

For example, there is a requirement to provide activities and entertainment:

One facility's interpretation of this standard results in an engaging music-based programme utilising age-appropriate music.

Another facility will run a programme based on music which is totally inappropriate for the clientele, providing no stimulation or engagement.

When documenting the activity, both meet the standard with a tick in the box. It all looks good on paper and at the accreditation inspection.

Raising standards alone is not enough, if there is a lack of training and no budget to provide the appropriate tools necessary to facilitate a worthwhile programme.

As an outside observer I find, with the current regulator-compliance approach, many residential staff live in fear of an accreditation inspection; some staff members won't even entertain the idea of meeting with me within the week or so leading up to the inspection. This appears to be a stressful period for them. With the further introduction of spot checks, many staff are terrified. If the facility is not up to standard then they should be afraid, however the tension also exists in many places operating well within the standards.

The implications of this are:

1. **The regulators must work with the industry collaboratively and not stand over them.**

2. When regulators implement new standards, **careful consideration should be given to the impact these may have on staff workload**.

3. **Regulators need to constantly review current regulations with a view to simplifying them where possible.** A burgeoning bureaucracy will significantly reduce staff time available to do the work they were employed to do.

4. Regulators should never push their own agendas during an inspection.

I was horrified when the manager of a facility told me she was 'ticked off' by an accreditation inspector for displaying a 'gender specific' picture on the wall. It was a jigsaw of a man and a woman holding hands, which had been put together by the residents and framed and hung on the wall.

There were LGBTI residents in the facility, none of whom had ever complained about the picture. The residents where all happy and living in complete harmony.

While times have changed for the better regarding acceptance of the LGBTI community, we need to be careful not to create an agenda because of this change. The manager's decision to leave well alone in this instance, was a wise one.

NEW STANDARDS

I have copies of the new standards which I have reviewed. In theory, they point in the right direction. Logistically, I see many challenges associated with implementing them under the current status quo; for all the reasons we have already covered in this paper.

A focus on person-centred care for the residents in aged care is well covered in these standards. However, this approach remains flawed unless serious consideration is given to:

1. **Creating an acceptable culture in the working environment through development of policy that ensures all staff are treated respectfully and courteously**. (HUMAN FACTORS)

2. **Equal sharing of workload through the provision of adequate staff numbers**.

3. **Appropriate training provided for caregivers, Lifestyle and Activities staff**.

4. **A realistic budget to purchase quality resources to support the work, in order to achieve the required standards**.

VALUING AND EXPANDING THE PROFESSIONAL LEISURE AND LIFESTYLE WORKFORCE

If **Leisure and Lifestyle roles were consolidated under one umbrella and educational standard**, through Diversional and Recreational Therapy Australia accreditation for example, the disparity, as discussed in the final two paragraphs of the section: 'UNDERSTANDING THE GENESIS OF AGED CARE' (page 8), would be addressed. This would ensure that all facilities were able to provide those in their care with professionally designed Leisure and Lifestyle programmes to suit each individual's abilities and preferences, thus guaranteeing the best possible quality of life for everyone.

UNIVERSAL TRAINING IN NON-TECHNICAL SKILLS

I believe a better way to effect positive change within residential care would be through the **introduction of a mandatory Non-Technical Skills (NTS) training programme**, also known as a Human Factors Training Programme, embracing all staff working at all levels within the industry.

As we have looked at the Leisure and Lifestyle role in residential care it has become quite clear how 'human factors' have impacted this role since its inception.

NON-TECHNICAL SKILLS TRAINING INTRODUCTION

Human Factors Training was introduced to the aviation industry in 1987 during my early years in the profession. (ref: https://www.atsb.gov.au/media/32882/b20060094.pdf ATSB SAFETY INFORMATION PAPER B2006/0094 'A Layman's Introduction to Human Factors in Aircraft Accident and Incident Investigation' page 7.)

This worked so well in the aviation industry, that Human Factors Training has expanded to other professions, where it is now referred to as Non-Technical Skills (NTS) training; a training programme the Aged Care Industry needs to embrace to effect culture change in the workplace environment.

AIMS OF NON-TECHNICAL SKILLS TRAINING

NTS training is designed to educate people engaged in a diversity of roles at all levels, to think differently about how they work together as valued and respected members of a team. The aim is to transform the current broad variation in industry culture, built around a vertical, hierarchical management structure, to a culture based on teamwork. This means the various roles, Leisure and Lifestyle included, are **connected synergistically with a focus on quality outcomes that are recognised and standardised industry-wide and documented as company policy**. It becomes the platform where conflict management takes place. There is a right way to go about this, which is where Human Factors Training equips all staff with the communicative skills to manage any situation or area of conflict that may arise. A successfully run NTS training programme affords everyone at all levels, the right to an equal say or redress without fear of recrimination or retribution.

As you can see, this would facilitate a wholistic approach to residential care, with a focus on the quality of the workplace environment for staff, in addition to the current focus on quality of client care. A happy staff will facilitate collaborative teamwork that affects positive outcomes for everyone. NTS Training, if properly implemented, will propel the aged care industry out of its inherent 'soft-hospital' culture, dominated by a hierarchical management structure.

An NTS training programme would not only address human behaviour in the workplace, it would also serve as a platform for industry regulators to provide a curriculum designed to educate staff regarding industry standards and best workplace practice.

The Human Factors Training programme I recommend is based on the aviation model, a comparative model I briefly touch on to illustrate my point. For this to work effectively in the aged care industry, a programme of this nature would need to be implemented at a regulatory level rather than an organisational level.

All levels of the industry would be required to participate, from CEO's, management, administration officers, receptionists, care staff, Leisure and Lifestyle staff, and any other people providing a service to aged care. Even cleaning and maintenance staff could be involved. NTS training usually involves an initial course followed by ongoing training one, maybe two days per year.

However, the introduction of an NTS Human Factors Training programme does not negate the need for appropriate numbers of qualified staff to share the workload, nor the provision of better resources and decent budgets, all of which are issues Leisure and Lifestyle staff currently face and which need resolving.

NTS training must not be perceived as a quick fix within care services.

Some people, no matter how much training you give them, may never change their ways. However, **a properly implemented Human Factors Training programme aims to address this issue.**

WHY HUMAN FACTORS?

We live in an era where academic qualifications play a major role in attaining workplace positions. However, a university degree does not train character. Character in individuals develops from many complex inputs in a person's life i.e. genetics, temperament, personality, upbringing, cultural background, environment etc. Therefore, two individuals with equivalent professional qualifications exposed to any given situation, will most often respond or react in different ways.

Human Factors Training aims to educate us to think differently about how we articulate our various roles in a respectful and courteous manner, to ensure all individuals feel they are respected members of the care team. The programme focus is on **working towards better more positive outcomes in <u>all</u> situations at <u>all</u> levels**.

Human factors in aged care would be a programme aimed at improving interpersonal skills learned through training and practice, which would lead to more effective teamwork between the various roles engaged in elder care. The programme offers a solution that will curtail unacceptable cases of bullying that tend to occur in the workplace environment under the current top-down management hierarchy of so many facilities. There are many incidences of bullying in the workplace, under this style of management, but it is a topic that generally, nobody wants to talk about.

Human Factors Training offers people at all levels an equal voice, rather than being dominated by hierarchical opinions. The programme aims to address communication issues between different roles, which can have an impact on care outcomes. It identifies what is acceptable and unacceptable behaviour. Rude co-workers at any level ruin the company. All too often the culture in a facility is determined by the manager. Human Factors Training aims to dismantle this vertical management structure and create a **horizontal model, where each role is respected, and communication and policy rubrics are established to facilitate <u>collaborative teamwork that affects positive outcomes</u>.**

An ideal facility governance is focused on achieving best outcomes, not only for the residents, but also for staff and others who offer support services.

Often the gradient that exists in the aged care management hierarchy is one of dominance and subordination and the culture in a facility is determined by one person: the manager. An effective manager equates to good culture, and a bad manager has the opposite effect. Human Factors Training addresses this anomaly.

A COMPARITIVE MODEL

Human Factors Training is a subject I can throw significant light on following a lifelong career in commercial aviation. The government in its wisdom, through its civil aviation branch, mandated Human Factors Training as a requirement for the holding of, and annual renewal of, an aircrew class 1 license. I believe the implementation of a similar programme in aged care would effectively transform industry culture in a positive and proactive way over time.

As stated earlier, Human Factors Training had its beginning in the Aviation Industry in 1987 under the guise of Crew Resource Management (CRM) training.

What I enjoyed most about my exposure to the aviation industry was that everything was leading edge. It had to be. When pushing several hundred tons through the air at 80 percent the speed of sound, there are certain disciplines in place that ensure every one arrives at their destination safely.

However, the one weak link in the industry was human factors. You may not know much about flying but everyone is familiar with human error associated with aircraft incidents.

Let me paint a picture of a worst-case scenario in aviation culture, prior to the introduction of a Human Factors Training programme:

As a young, freshly trained crew member, I was assigned to fly with a grumpy old guy almost ready to retire. When he was young, he had been a war-time pilot and had never flown in a support crew role in his life. Therefore, subconsciously he resented having anyone else in his cockpit.

In this instance, I could see something which could potentially threaten the safety of the flight, however, I was aware that pointing this out, would probably result in him berating me. With this in mind, I was reluctant to say anything. He didn't communicate his awareness of the situation to the crew, so I had no idea if he had seen it. If he wasn't aware, and I didn't speak up an accident would result. Had we survived to tell the story, an enquiry would want to know if I had been aware of the situation and if so, why I hadn't spoken up. I would have to reply that I had been afraid to speak up because of the perceived repercussions. This is what is referred to as a management gradient.

Because of several other human factor related incidents that occurred in aviation, governments around the world mandated all crew to attend Human Factors Training as part of their annual license renewal. Aptly named Crew Resource Training, it later was referred to as CRM or Crew Resource Management.

Pre and post Human Factors Training all crew where competently qualified to do the job. All had passed regular simulator and line checks and were therefore, legally qualified to perform their particular roles, **but this did not address the varying levels of personal development in individuals**. As stated earlier, two individuals with the equivalent professional qualifications will invariably respond or react in different ways to any situation.

CRM over the years, changed the culture in the industry through educating human behaviour. The cockpit gradient that existed is no more, and captains who asserted their authority in a stand-over and intimidating manner would be subject to company disciplinary action.

What I remember well was the reaction by crew to the idea of Human Factors Training being introduced. Those who needed it the most, thought of it with disdain, while those in more

subordinate roles thought it was a marvellous innovation. I imagine the general reaction to the introduction of a similar programme in aged care would be much the same, as the inherent power and control of some, is threatened by such a programme.

NTS TRAINING APPLIED TO AGED CARE

Non-Technical Skills (NTS) Training is a Human Factors Training programme that covers cognitive, social and personal resource skills through the delivery of standardised training modules. This approach has now moved from its inception in the aviation and oil industries, to a much wider sphere of practice, including areas of healthcare, such as surgery and emergency medicine. These are all spheres where the **safe and effective delivery of care relies very heavily on teamwork**. The training helps to define interrelated behaviours, actions, cognitions, and attitudes that facilitate teamwork.

The need for Non-Technical Skills training in the aged care sector is becoming increasingly obvious, as we identify areas where specific role training does not ensure the automatic ability to perform well as a team when different skill-sets are brought together. Effective teamwork; non-confrontational team leadership; and clear communication, such that all concerned parties have the same perception of what is meant to happen in a residents' care plan, cannot simply be assumed.

The object of the programme is to address human factors that can impact negatively on the overall care programme and educate alternative approaches, cohesive teamwork etc.

To be effective, all staff engaged in the aged care industry from top management down, should be required to attend an accredited NTS training course as a mixed group.

To maintain competency everyone in the industry would be required to attend an initial NTS training course, followed by one or two days per year of programme training, which would count towards CPD points. During the course real-life scenarios form part of the group discussion. The case studies do not identify names or places. They invite comment from participants at all levels, to contribute their ideas and suggested courses of action and solutions.

For example:

CASE STUDY 01: NEGATIVE OUTCOMES

During the early days of my engagement with aged care, I was visiting a facility. While waiting for a carer to meet me, a resident with dementia recognised John Sidney's picture on a CD I was holding. She was excited as she was very familiar with his music. She returned to her room to get some money to purchase the CD. Just as she returned however, and was passing me the money, the carer arrived, snatched the money out of her hand, looked at me with a scowl on her face and said, 'We're familiar with your product and we'll be in touch'. This is a typical fob off; one I have become all too familiar with. The carer was technically right in doing her job and abiding by rules that ensure hawkers don't rip money off their clients. But let us examine the outcome.

The net result was:

1. The resident turned away dreadfully disappointed. I will never forget the look on her face, and to this day I live with the guilt of being too shocked to just hand her the CD as a gift.

2. Having spent 40+ years in the aviation industry I was quite accustomed to being treated with dignity and respect. Shocked at the carer's rudeness, at that point, I nearly walked away from what I do. The only thing that kept me going was thinking of the people, like this lady with dementia, who are on the other side of this 'people game' we seem to play.

In conclusion, even though the carer was adhering to establishment rules, the situation was poorly managed as gauged by the negative outcomes for the client.

A situation like this would be used during the NTS training course for analysis by the group (no names or places mentioned). On examination, was the outcome a good one or a bad one? Did the carer manage her role correctly? Should the resident have been engaged in what was happening at that moment? How could the carer have handled the situation differently to achieve a better outcome for the resident? etc.

ELDER CHOICE

What disturbed me most about the above incident was the obvious lack of freedom of choice afforded this lady. The way the establishment rules were managed, took that away from her.

Prior to my involvement with aged care I had some exposure on radio, through Chris Wisbey's show on ABC Radio Hobart, and in Sydney, through the Graeme Gilbert show on 2SM and the Bob Rogers show on 2CH, among others. These programmes appealed more to senior citizens and some of the myriad of correspondence I received can be viewed on the 'Testimonials' page at www.evergreenmelodies.com and www.agedcaremusicresources.com .

When it comes to freedom of choice for the elderly, there exists a huge contrast between those living independently and those living in an institutionalised environment. In the latter situation the elderly lose their independence and right to choose.

The following two testimonials, published with the resident's permission, are compelling reading.

I met Lyla when I called in with John Sidney's music. The carer purchased a CD for her while I was there and the rest, you will find quite moving. At times I still get emotional when I share her story.

Lila's letter to Graeme – Aged Care Music Resources

The other is Norma, who contacted my wife after hearing my interview on radio with Graeme Gilbert. You will find her story moving too. Norma phoned Graeme Gilbert and he forwarded a copy of her call which you can hear via a link in my notes next to Norma's letter.

Letter from Norma in Newcastle, NSW – Aged Care Music Resources

Both these incidents demonstrate a complete disconnect between care staff and resident needs, beyond the basic.

PART 2 CONCLUSION

In search of a solution, the aged care industry and the associated Royal Commission would do well to **consult with experienced, highly qualified staff who work directly with residents.**

I list a few who have crossed my path in PART 5 of this paper. I am sure there are many others who if not already doing so, would also be willing to contribute. Their experience, knowledge and opinions are invaluable; born from a hands-on understanding of the needs of those they care for.

This bottom-up approach may be the answer as the current top-down approach has led us to where we are today, culminating in a Royal Commission looking into Aged Care.

Building from a workforce knowledge base assures a more productive and realistic outcome than one based on unresearched opinion, often influenced by vested interests and the personal agendas of those at higher levels of the hierarchy. So much is lost through the layers when working from the top down. More often those at the top have little or no idea what goes on in the front line. One day I was listening to a politician who, although responsible for the aged care portfolio at the time, clearly demonstrated by what he was saying, that he had no idea what was going on at the grass-roots level of the portfolio he was managing.

When I refer to knowledge base, I do not mean that in the academic sense. I am talking about knowledge gained from hands-on experience by people working at the coalface. No one knows it, or sees it, like they do.

PART 3 THE IMPORTANCE OF MUSIC IN RESIDENTIAL AGED CARE

The importance of age appropriate music in a residential care environment cannot be over-emphasised.

Despite knowledge gained from research, endless anecdotal evidence, and the recent spate of media exposure this topic has received, **music in general, is still undervalued and therefore underutilised in the aged care environment**.

At a human level we know there is a close connection between music and emotions. Neurological research explains how during 'happy moments' endorphins are released into the blood stream, which positively affects one's overall sense of well-being. As numerous studies have proven, one of the most powerful tools to support mental health and improve quality of life is age-appropriate music. Life could be so much better for elderly people living in care if we applied this knowledge.

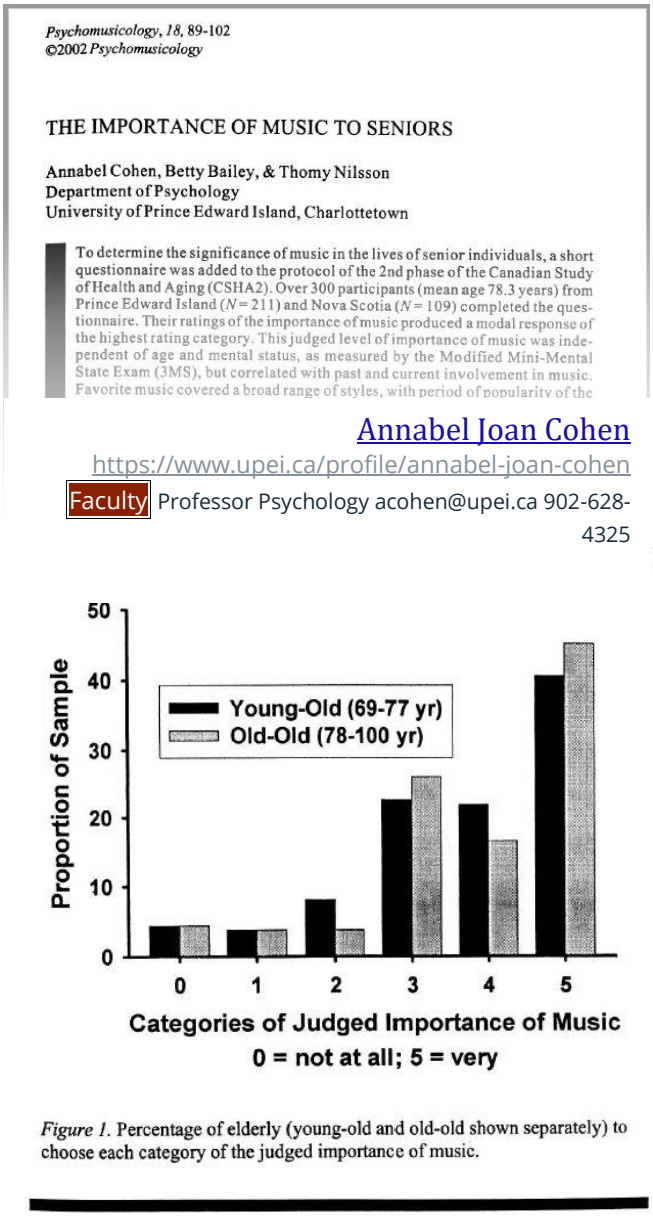
RECOGNISING THE VALUE OF MUSIC IN RESIDENTIAL CARE

Research into reminiscence therapy shows people with dementia respond to the music of their youth. It gives them a sense of value, belonging, power and peace. Brain specialists tell us music is the last thing to go. Neurologist Oliver Sacks writes in his book *Musicophilia,* 'Musical perception, musical sensibility, musical emotion and musical memory can serve us long after other forms of memory have disappeared'.

An extensive research study on 'The Importance of Music to Seniors', was conducted by the University of Prince Edward Island in Charlottetown, Canada in 2002. The study concluded with overwhelming evidence supporting the importance of music to the elderly.

This research states that music from 'the period of 10 to 30 years of age produces the most autobiographical, vivid, and important memories'. Diversional Therapists and Aged Care Recreation Officers can use music as a gentle way to improve the well-being of their elderly clients. By playing music that resonates with their clients and brings back happy memories of their younger years, music can be used to genuinely engage the elderly so they develop a stronger sense of community and friendship among their peers and find greater joy in everyday life.

Age-appropriate music is a powerful, non-invasive tool that improves mood; stimulates memory; encourages spontaneous physical activity; provides a culturally appropriate experience; and promotes social interaction**, but staff need to be trained in its appropriate selection and use.**



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THE IMPORTANCE OF MUSIC TO SENIORS

Annabel Cohen, Betty Bailey, & Thomy Nilsson
Department of Psychology
University of Prince Edward Island, Charlottetown

To determine the significance of music in the lives of senior individuals, a short questionnaire was added to the protocol of the 2nd phase of the Canadian Study of Health and Aging (CSHA2). Over 300 participants (mean age 78.3 years) from Prince Edward Island ($N = 211$) and Nova Scotia ($N = 109$) completed the questionnaire. Their ratings of the importance of music produced a modal response of the highest rating category. This judged level of importance of music was independent of age and mental status, as measured by the Modified Mini-Mental State Exam (3MS), but correlated with past and current involvement in music. Favorite music covered a broad range of styles, with period of popularity of the

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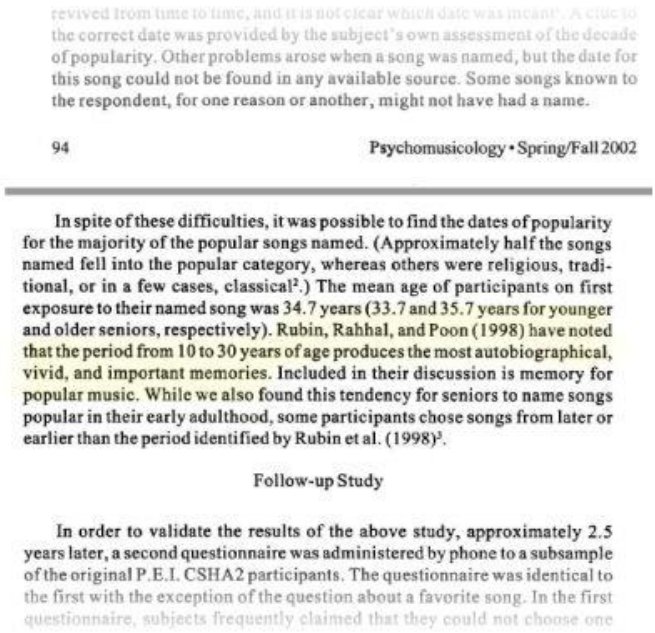
Figure 1. Percentage of elderly (young-old and old-old shown separately) to choose each category of the judged importance of music.

Music is the simplest, most powerful tool to engage with the majority of elderly residents, particularly those suffering from dementia, **but again, staff need to be trained in the appropriate selection and use.**



revived from time to time, and it is not clear which date was meant'. A clue to the correct date was provided by the subject's own assessment of the decade of popularity. Other problems arose when a song was named, but the date for this song could not be found in any available source. Some songs known to the respondent, for one reason or another, might not have had a name.

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In spite of these difficulties, it was possible to find the dates of popularity for the majority of the popular songs named. (Approximately half the songs named fell into the popular category, whereas others were religious, traditional, or in a few cases, classical[2].) The mean age of participants on first exposure to their named song was 34.7 years (33.7 and 35.7 years for younger and older seniors, respectively). Rubin, Rahhal, and Poon (1998) have noted that the period from 10 to 30 years of age produces the most autobiographical, vivid, and important memories. Included in their discussion is memory for popular music. While we also found this tendency for seniors to name songs popular in their early adulthood, some participants chose songs from later or earlier than the period identified by Rubin et al. (1998)[3].

Follow-up Study

In order to validate the results of the above study, approximately 2.5 years later, a second questionnaire was administered by phone to a subsample of the original P.E.I. CSHA2 participants. The questionnaire was identical to the first with the exception of the question about a favorite song. In the first questionnaire, subjects frequently claimed that they could not choose one

DEPRESSION AND THE ELDERLY IN CARE

Social isolation is a risk factor for depression and suicide in the elderly.

A survey was conducted by the Australian Institution of Health and Welfare 2008-2012 titled, 'Depression in residential aged care' (full publication; 27 September 2013), which revealed that **more than half of all permanent aged care residents in Australia have depression.**

More than 53 per cent of women and 51 per cent of men living permanently in aged care, the study found, had symptoms of depression. This is an alarming finding for everyone involved, from residents to relatives, to friends and carers, these statistics are incredibly sad, especially as it doesn't have to be the case.

Through this survey it has become evident that a soft-hospital culture in aged care is clearly not meeting the psychological, spiritual, social, emotional, and physical well-being needs of individuals.

The role of qualified care givers engaged in facilitating Leisure and Lifestyle programmes is core to meeting both the spiritual and well-being needs of our elders in care.

Music is the easiest and most powerful therapy for engaging with our elders. When correctly utilised it makes the facilitator's role a much easier one.

Music also eases the workload for carers, as their residents while away many hours each day reliving their memories as they listen.

PIANO MUSIC: A TONIC FOR THE AGED

Appropriate piano music for the elderly, produces a certain resonance and harmonic structure which can activate brain chemistry, thereby triggering the production of endorphins (happy hormones) into the body systems, resulting in a feeling of well-being. This feeling can endure for many hours and even days, after the experience of hearing piano music. The advantages of this musical effect can be most helpful in the life of an elderly resident.

UNDERSTANDING THE EARLIER LIVES OF THOSE IN CARE

Besides the amazing people working in Leisure and Lifestyle who I spoke about earlier, I also come across staff who are not adequately trained in administering a meaningful and engaging Lifestyle programme. One of the first questions I usually ask of them is how much they know and understand about the early life of those they care for? To my astonishment, generally the response is, 'Very little'.

A common pushback response when I visit facilities is that they already have a weekly, or perhaps monthly entertainer, or volunteers who attend regularly to run activities. This is a bit like telling me they live on a diet of birthday parties. But what about the in-between times?

I grew up in the 1950s, on a farm pioneered by my ancestors in the southwest of WA. There was no television in those days. In most homes there was a piano. If they could not play piano, they bought a pianola.

I remember as a child, our farmhouse was the regular communal gathering point. Many a Friday night there would be a group of men in one corner of the lounge chatting with a beer in hand, a few ladies sitting around the fire knitting and nattering, and mum playing the piano while people sang along.

Many eighty or ninety-year-old people currently living in residential aged care facilities are from a generation that worked for the same company their whole life; lived through war; survived the depression; and went without to provide for their families. Their lives revolved around music, mateship, and hard work.

There wasn't a lot of money around in those days, so they created their own entertainment. The dances and the sing-alongs were a central part of their lives. It was music that carried them through hard times like the Great Depression and the World Wars.

Many young Leisure and Lifestyle staff have no knowledge of this.

THE GENERATION GAP

A major contributing factor to the lack of appreciation for age appropriate music is the generation gap between caregivers and their residents. Particularly where eighty and ninety-year-old's are being cared for by young staff. Often the younger staff fail to recognise or appreciate the value of the music resources we have produced to support the work of Leisure and Lifestyle staff, due to a lack of understanding of the life those they care for lived when they were young, let alone their taste in music.

Furthermore, many staff employed to conduct Leisure and Lifestyle programmes come from a completely different cultural background to those they care for. Therefore, they have very limited knowledge and understanding of the culture of the older person. As I became involved with the aged care industry, I realised that **the challenge the Leisure and Lifestyle sector faced was not only generational, but also cultural**. Staff often assess music based on their own personal taste. This is where **training in the selection and use of music is so important.**

MY MUSICAL JOURNEY: WHERE IT ALL BEGAN

At the turn of the century during my flying years, I had a chance meeting with a talented pianist named John Sidney, in Hobart. Although I was unaware at the time; it was a meeting destined to alter the direction of my life.

Any well-played piano gets my attention and John Sidney would be the best dance-stride style pianist I have ever heard. I became his friend and funded him to record his music for my own personal collection. My focus then was on preserving his works for posterity, as I understood once his generation passes on, that style of playing will be lost forever.

Before John died in 2002 he gave me ownership rights to his works as he said, 'If anyone is going to keep my music alive, it will be you'. At that time, I had no idea how I would achieve that as, up until I had this brush with the entertainment world, my whole life had been about aeroplanes and farming.

The full story about how I met John Sidney and became involved with his music can be read online at: Aviators Passion – Aged Care Music Resources . After reading the article you will become aware there is far more behind my involvement with his music than a mere commercial interest.

MY MUSICAL JOURNEY: RESIDENTIAL AGED CARE

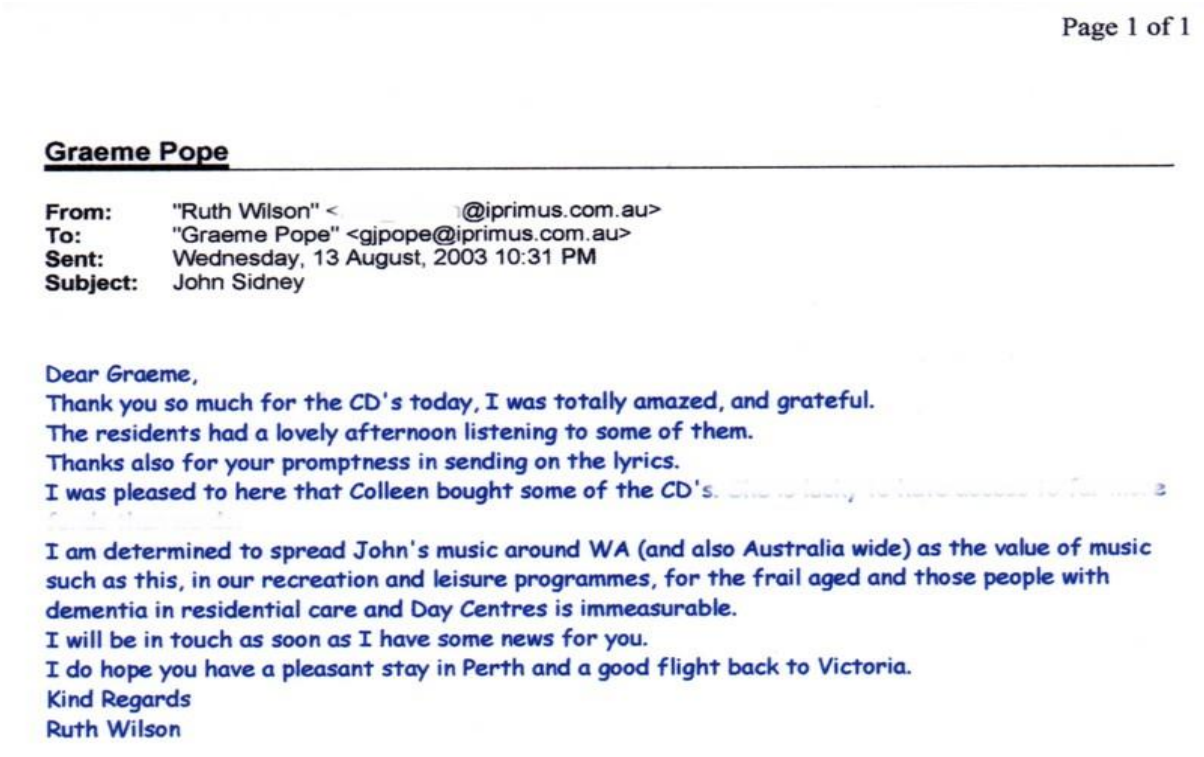
My journey in aged care began after being encouraged by friends working in a local aged care facility, to promote John Sidney's music to the industry. They told me what I had in my hands was gold for those they cared for.

As I began visiting aged care facilities in 2003, I became quite disturbed by all this 'grey' sitting around half asleep, bored, and totally unstimulated. Their situation ignited the passion that drives me today.

Whenever I had the opportunity to demonstrate John's music in these facilities, the response was amazing. The spontaneous joy on their faces was obvious as the residents connected with the sounds of songs they knew. They enjoyed John's piano immensely as it relaxed them and took them back to the 'old days'.

The response from aged care staff, however, was often quite abysmal, which was very discouraging.

My first steps in marketing John's music to aged care facilities began in Perth in July 2003. After a couple of weeks, I felt disheartened as the response wasn't what I had expected. Then fate intervened, when, at my very last facility visit before departing Perth, I met Ruth Wilson, the Diversional Therapist at the Waminda Hostel. Her enthusiastic response to John's music was the kind of response I had been expecting from people working in Leisure and Lifestyle; sadly, that generally is not the case. This is the email I received from Ruth after my visit:



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Graeme Pope

From: "Ruth Wilson" < @iprimus.com.au>
To: "Graeme Pope" <gjpope@iprimus.com.au>
Sent: Wednesday, 13 August, 2003 10:31 PM
Subject: John Sidney

Dear Graeme,
Thank you so much for the CD's today, I was totally amazed, and grateful.
The residents had a lovely afternoon listening to some of them.
Thanks also for your promptness in sending on the lyrics.
I was pleased to here that Colleen bought some of the CD's.

I am determined to spread John's music around WA (and also Australia wide) as the value of music such as this, in our recreation and leisure programmes, for the frail aged and those people with dementia in residential care and Day Centres is immeasurable.
I will be in touch as soon as I have some news for you.
I do hope you have a pleasant stay in Perth and a good flight back to Victoria.
Kind Regards
Ruth Wilson

Meeting Ruth at that point was the catalyst behind what I am doing today. If I had not met Ruth in Perth that day I would have walked away from aged care. What drives me today is my concern for the lives of those living on the other side of this 'people game' we play, as demonstrated in CASE STUDY 01, page 20.

While marketing John's music to aged care over many years, I have continually observed inappropriate music being played in aged care facilities.

The lack of sales to aged care is not a negative reflection on the quality of this product or the appropriateness of this music for the aged, but sadly, it reflects the all-too-frequent lack of empathy I have found in those who care for the elderly. It also reflects the carers' own tastes in music and their own needs and wants in this area.

Finance was not a consideration back then as I was well established selling John's music worldwide via the internet and Australia-wide through radio. I was trading under the business name evergreenmelodies.com, and with stock in hand, funding, and resourcing during those early years of engagement with the aged care industry wasn't an issue.

CASE STUDY 02: AN INDUSTRY DEVOID OF EMPATHY

My association with the aged care industry during the first nine years was solely promoting John Sidney's piano music to residential aged care. During that period, I was invited by a large organisation to attend a function held in Sydney where I supported their fundraising silent auction by donating three boxed-sets of John Sidney's CDS.

I had developed a good rapport with the event organiser and assumed that during the silent auction brief they would include an introduction to John's music CDs and their relevance to aged care. Had she mentioned that the boxed sets of John Sidney CDs donated by EvergreenMelodies were currently being advertised on radio 2CH, I'm sure many attendees would have immediately connected with that, but for some reason she resisted doing so.

The end result was her embarrassment when there wasn't one bid on the CDs; people had no idea what they were. The reality is, as I mentioned to her, it costs us more to market the music to the aged care industry than we make out of sales to aged care. She was disbelieving, however the fact is, that I never made one sale from this exercise while incurring travel and accommodation expenses.

This lady was also the organiser for an aged care conference to be held the following morning near where I was staying, and it was being attended by 250 delegates from within their organisation. She invited me to attend as she wanted to introduce me to two 'key people' in their organisation. She also said she would play John's music during conference breaks and make an announcement accordingly, which she did.

She also placed a table for me to place my brochures on. The two 'key people' she wanted me to meet were very polite, but I sensed they were not that interested in meeting me or knowing about John's music; they were just going through the motions.

I looked around as John's music was being played and not one person out of the 250 attendees seemed to recognise or acknowledge how much the residents in their care would appreciate this music. No-one even picked up the brochures.

For me, this has truly been a labour of love for the aged in care, buoyed only by the fact, as you will observe from the correspondence we have received from our clients, this music is priceless to the elderly. Their letters make all the effort worthwhile. This begs the question, why is this so hard? It should not be. I have been asking this question of myself constantly over the past 10 years and I think I have finally worked it out. John's music is a bit like a diamond in the rough, to the untrained eye it is just another stone trodden under foot. To the trained eye its value is instantly recognisable. Sadly, and alarmingly, there are not too many 'trained eyes' in the aged care industry when it comes to identifying appropriate music for our elders in care.

My wife Sandy understands my passion for John's music and the positive impact it has on the lives of the elderly, saying from the beginning she didn't mind how much time and work I put into it as long as we didn't end up funding it out of our superannuation. She insisted the business must be financially self-supporting which was not an unreasonable request. I gave her that assurance. Although we are out of pocket in our endeavours to market John's music to facilities, we have managed to subsidise those losses from sales we make outside of aged care via the internet, radio and other venues.

Because of the poor sales response from the aged care industry Sandy was incredulous at my persistence in trying to reach the aged in care with this music, until one day she read a couple of letters we had received from clients and said, 'Now I understand why you are doing this'. But what this clearly reveals is that **elderly folk outside of care have a freedom of choice that those in care are generally deprived of.** Someone in the institution of aged care makes choices for the residents which are not evidence-based and not always in their best interests (see CASE STUDY 01 Page 20).

MEETING THE NEED

Most aged care facilities in Australia and New Zealand were very familiar with the 'Blue' and 'Red' Large Print Songbooks published by Ulverscroft back in the late 1970s. These popular songbooks have been used in residential care over many years, however, many facilities were finding it more difficult to find a pianist who knew those songs, to play for their music activities.

As I visited more aged care facilities, those familiar with my association with John Sidney's music would request music to back the songs in the Ulverscroft Large Print Song Books. They imagined his piano behind those songs. Sadly, John died in 2002.

A few years after John Sidney died, I had the good fortune to meet Barry Hall OAM in Adelaide. Barry was Mr Music on the Chanel 9 children's programme in the early days of television when Humphrey B. Bear first appeared on television. He ran the top-rated radio programme 'Choose Your Own' on Adelaide's 5DN for 20 years. When I told Barry about the requests I continually received from Leisure and Lifestyle staff, he enthusiastically embraced the challenge to record 381 songs to back every song in those songbooks.

Ulverscroft in the UK granted us permission to mention their name on the front cover and to match the music to the index in their songbooks. Two years later in July 2014, after completing a market survey to ensure a demand existed, we released our flagship music resource, the Blue and Red Book CD Collection; an audio companion specifically designed to match and back the songs in those songbooks.

AGED CARE MUSIC RESOURCES

As you will have gathered, my work with the aged care industry is not something I set out to do. It is a business that evolved out of a passion for the care of our elderly. I realised from the beginning how

the right music, when correctly managed, can have a huge impact on quality of life for residents in care, especially those suffering with dementia. Hence our motto 'Music makes a world of difference to the elderly'.

I founded Aged Care Music Resources in 2014, and I collaborate with a team of professionals to produce music-based resources by industry request. The genesis of the idea came from those engaged in Leisure and Lifestyle work in residential care.

They are quality tools designed and tailored to meet musical needs in aged care. Each resource has been crafted to meet specific requirements in Leisure and Lifestyle programmes and created in collaboration with staff engaged in this field of work.

During the production process, careful consideration was given to content, design, functionality, and durability, to ensure they are valued resources in any aged care facility activity toolkit. They are tools designed to support the work of Leisure and Lifestyle staff, the key points being:

1. The music, recorded in studio by two professional old time Australian pianists, is age appropriate.

2. The music resources represent good value considering the amount of music and the quality.

3. These resources save session planning time by supplying music that matches the lyric books.

4. The comprehensive music library allows for the choice of music that has specific meaning to each person.

5. With all four major resources there is music to draw on for any occasion.

6. Music is fully compliant with copyright law.

TESTIMONIAL

22nd December 2017

I have been using the red and blue book recordings for the last couple of months and highly recommend them. I am a music therapist in a high care dementia ward. The backings are great, easy for the residents to follow and well recorded. They are better than the ones I had been using from iTunes. The CDs are really good value for the amount of music and quality. I have just bought the green CDs for our younger residents and look forward to using them. On a planning side it's lovely to have so much music at my fingertips that match the lyric book so I can pick music that has specific meaning to each person I am with.

Thank you for offering such high-quality resources.

Layla, Brisbane

For any facilitator to fully reap the benefits of these resources, they **need to have a respect for the value of singing and music. Their involvement and creativity are also crucial**. Without these in place, the value of these resources would not be realised. Just acquiring this music is insufficient; equally as important is how it is used and managed. The music has been chosen for the connection it provides to the era and style of entertainment familiar to the elderly.

Although I repeatedly stress the need for staff to be trained in appropriate music selection and use, with these resources the selection has been made for them.

DISTRIBUTION

I have spent the past 16 years self-funding Aged Care Music Resources (evergreenmelodies.com, initially), producing the music the elderly love, manufacturing it, and driving to aged care homes across Australia to distribute it.

I cold call aged care facilities to show-and-tell, as I figured for them, a hands-on introduction far outweighs reviewing them on a screen or piece of paper. Usually they consider it a privilege that someone has gone out of their way to do that for them.

I do not have to sell them. Those professional in their field immediately recognise them as the tools of trade that they are. On my part I only need a few minutes of their time to do this, however I like to give staff all the time they need during my visit. Because of this it is not logistically possible to book appointments in advance. However, for over 2000 visits I can count on two hands how many times I was reprimanded for not making a prior appointment. The conversations I have enjoyed with industry people is the major source of my education about the aged care industry.

DEFINING MY ROLE

During one facility visit, I was standing outside the open door of a manager's office talking to two Leisure and Lifestyle staff when the manager overheard our conversation. Intrigued, she joined us and even after the Lifestyle staff returned to their work, the manager took the time to explore who I was and why I was there. In the end she said, 'You know Graeme there isn't another person in Australia doing what you do. What you are doing is coming to us with a skillset and you are saying to us, how can I help you?' She followed through by saying, 'There are lots of resources like these we would like to make but we would have no idea how to go about it, and even if we did, we wouldn't have the time to do it.' With that she exclaimed how she loved partnerships and that is how she defined my role.

In these resources, Leisure and Lifestyle staff have, at their fingertips, music to suit any occasion which negates the need for them to spend many hours of their own time researching and sourcing appropriate music and managing an out of control CD library. These resources save them a lot of session preparation time. They are tools specifically designed to support the work they do. But for that to work, **they need to know how to use them!**

CHALLENGES FACED BY A PRODUCER OF MUSIC-BASED RESOURCES

Quality Australian made resources like these are a rare commodity in Australia. To this day, I am grateful to a wonderful team of professionals, both inside and outside the aged care industry, who have helped us put these unique music-based resources together. I could never have done it alone.

To give you an idea what I am referring to, these resources can be examined on our website

Aged Care Music Resources – Music Makes a World of Difference To The Elderly

Producing specifically designed quality resources at a commercial level for a relatively small budget-sensitive audience in Australia, presents huge challenges. To put things in perspective, in a country like America, a company could produce ten times the resources I produce for not much more than the cost of producing 1000 units here. In the USA they have ten times more elderly in care than we do here in Australia, so for them it would be a financially viable proposition to produce them in such quantities. The more you produce commercially, the per unit cost reduces significantly. I cannot do that in Australia because my audience is too small.

Two other factors that apply upward pressure on costs is buyer resistance, largely brought about by the lack of available funds, and compliance costs (copyright and royalty costs).

The greatest challenge in running an aged care related business is competing for what relatively little funding there is available outside the basic needs of care. Many Leisure and Lifestyle staff are allocated meagre monthly budgets and therefore, end up purchasing cheaper resources with a relatively short life, or those designed for a specific activity. Many Lifestyle and Activities Coordinators end up purchasing our resources from their personal income or seek external funding because of budget constraints.

Striking the right balance between RRP of goods while covering business running expenses is a significant challenge when selling to a budget sensitive industry, where the price of your products may often be perceived as expensive.

During the time I have been involved with the aged care industry, I have noticed a gradual retraction in funding and resourcing in Lifestyle.

If the current underfunding trend continues, the quality of Australian made music-based resources available to Leisure and Lifestyle programmes will be reduced to that which is homemade, some of which are either noncompliant or are only partially compliant with copyright law. I am a stickler for compliance, and I have a good grasp of copyright requirements. It is exceedingly difficult to produce commercial quality music-based resources when competing with homemade or noncompliant cheaply produced resources.

Most businesses providing resources to support Leisure and Lifestyle programmes struggle to sustain financial viability. If it were a 'big money business' then I can assure you big business would be in there doing it, and they are not.

As long as government and management do not consider the importance of Leisure and Lifestyle in the overall residential care plan, this will always remain a challenge for anyone providing a service in this sector.

Heads of Leisure and Lifestyle were positions once held by highly qualified Diversional Therapists and experienced Lifestyle staff, often Degree, Diploma or CERT IV qualified and supported by a source of funding. Today, this role is more often filled by people with qualifications and background experience which is arm's-length from the Leisure and Lifestyle department they head. By design they effectively filter what funding is available to the recreation staff based on instructions from the top.

Unless there is a significant change in attitude by those administering aged care in this country, suppliers of commercially produced, quality resources to support the Leisure and Lifestyle role will diminish through lack of incentive to provide the resources that support this sector.

PIRACY

The current underfunded state of the Leisure and Lifestyle role has led to significant amounts of piracy of music and resources.

The government, along with many aged care providers, by not ensuring adequate funds are allocated to support this role, are unwittingly indirectly supporting the illegal practice of stealing copyright material!

During my travels I have gathered sufficient evidence to support this claim however, I would never unmask those who duplicate copyright protected material. Since they are not provided with sufficient funds to acquire the quality resources they need to support the work they do, too many are left with little choice other than to beg, borrow and steal the resources they need to facilitate their sessions. It's not as if they are earning huge salaries to afford to buy them themselves, nor should they have to.

The industry in general, turns a blind eye to this practice, while at the same time, regulators continually raise the standards these same people are expected to achieve.

Continually raising standards without providing the tools needed to help achieve those standards, places unfair demands on the skills of those fulfilling a Leisure and Lifestyle role.

With a Royal Commission into Aged Care, there is hope that this will change.

CASE STUDY 03: UNDERSTANDING THE EARLIER LIVES OF THOSE IN CARE

In conversation with a young lady from a foreign cultural background who worked in Lifestyle I asked her how much she knew about the life of those she cares for when they were young? Her response was that she knew very little. She had received minimal training for the role that carried a typical 'social director' job description of organising games and outings. In between times she was expected to fill in as support for the care team at mealtimes, as well as other menial tasks like cleaning out the bird cages.

This young lady was keen to learn about the life of residents in her care as she found herself bonding with them and was keen to deepen that connection, in learning about their life when they were young and the culture they came from. She would spend hours of her own time poring over the internet to glean as much information as she could.

Most residents in her care had dementia and since she already had all our resources, I suggested she treat them as 'work manuals'. I explained to her that she now had music at her fingertips to draw on for any occasion. They were her tools of trade. Any music played from the Blue and Red Book CD Collection would engage her eighty and ninety-year-old residents. Any music recorded on the Green Book CD Collection had been tailored to meet the needs of the baby boomer generation entering care; she need look no further.

As with many like her, I spent time coaching her in their use. I suggested she begin by finding out the favourite song of a resident and then learn the song herself. This done, she would be able to engage with the resident, putting the CD on the particular track so they could sing along together. The response would be one of joy, not only to the music, but to the individual attention.

Now a typical response I get from the young ones when I suggest they do this is they say they can't sing. This highlights the challenge faced by the younger generation where subconsciously they compare themselves with a lifetime exposure to 'perfection in presentation' on television. When we were young, no one cared whether you had a good singing voice or not, you just sang for the joy of it.

Young people like this, need coaching in running engaging music sessions with the residents in their care. I encourage them to do this on a one-on-one basis until they get the feel for how it works, and as they see it work for them, their confidence builds. I then encourage them to grow their group of participants incrementally, until one day they will find themselves confidently running engaging music-based sessions with larger groups of 10 to 15 participants.

In today's academic world we tend to leave tasks such as these to the experts trained in music therapy, however I believe it is feasible for most Leisure and Lifestyle staff to engage with their residents through music, whether they are musical or not. Some with a natural aptitude for music can do this well but others may need to be trained. Coaching of younger Leisure and Lifestyle staff by experienced staff is an effective way to achieve this.

If staff were trained to run simple sessions like this, there would not be the need to pay out money for specialists or outsiders to entertain them as frequently, or I should say, as infrequently as they do.

Aged care organisations who can grasp this concept will learn there are long term savings through efficient utilisation of staff, with lesser dependence on paying outsiders to perform activities and entertain. This could be handled adequately by appropriately trained staff who are already on the payroll, given the right tools. This simple approach works particularly well when engaging with those suffering from dementia.

The investment required in training staff would be relatively small and could save the Lifestyle budget over time. Lifestyle staff need quality resources to support the work they do and to assist them in attaining required standards. This is where my involvement with the aged care industry lies.

Good financial management is knowing how to spend money in the right areas to save money over the long term. Measured over time, micromanaged budgets imbue waste and inefficiency and often lead to business failure.

EMPATHY: THE ESSENTIAL INGREDIENT IN ELDER CARE

As I have already stated, many lack empathy for the life those they care for lived when they were young. This is usually not by any fault of their own, as generally I find they are a great group of people who genuinely desire to enhance the lives of our elders in care to the best of their ability.

A college degree cannot and does not, create empathy. We gain empathy by either living in the time or by listening to those who lived in a different time, tell their stories and share their memories. **Listening is key**, as you imagine yourself in their story telling, you get a feeling for what they are talking about. Empathy comes with listening and putting yourself in someone else's shoes. Unfortunately for many Leisure and Lifestyle staff, **listening to their residents tell their stories does not fit their job description**, yet surely, this is what person-centred care is all about.

As a producer of music-based resources for use in aged care this lack of empathy became obvious through the lack of familiarity of the staff, with the type of music that would engage their residents.

ENGAGING WITH RESIDENTS THROUGH MUSIC

Music is capable of rekindling precious memories and engendering feelings of joy, connection, and relaxation in the listener, even those suffering from dementia. Music is recognised as important for our elderly, particularly for those living in care, and yet I have found relatively little provision of age-appropriate music for people residing in Australian aged care facilities, particularly for those living with dementia.

The simplest way to engage with residents through music is to focus on what sparks spontaneity in them or calms them.

CASE STUDY 04: NON-PHARMA INTERVENTION

During my early years of taking John Sidney's music to aged care facilities, one Lifestyle Coordinator was telling me about a resident, suffering with dementia, who was screaming uncontrollably. She had tried everything that she knew of to deal with the situation and her next move was to go down the path of administering a drug. Before she did, she thought to try the John Sidney CDs she had just purchased.

Immediately the piano music began to play, the screaming stopped, and the LC told me the resident was asleep before the music CD had finished playing.

This of course may not always work in every situation; however, it is always worth a try. In this case it worked a treat.

Every possible intervention must be tried before using pharmacological interventions to relieve emotional or psychological distress.

CASE STUDY 05: AN EXAMPLE OF SPONTANEITY IN AN ACTIVITY

I called in to a facility in country NSW. I was led by the receptionist to the activity room where the Lifestyle Coordinator was about to begin an activity.

The facilitator asked who I was and on introducing myself and explaining why I was there, she invited me in. On sharing my story briefly with the residents, we put some music on to demonstrate it to them and the response was spontaneous. We had a lot of fun for the next 20 minutes when I noticed they had a piano there too, so I was able to spend time engaging them in piano music as well.

The LC thanked me for my visit, acknowledging that the residents had thoroughly enjoyed the experience and stating that the activity she had prepared for that day, could be conducted next week instead.

In this case the facilitator was flexible and in tune with her residents.

Needless to say, the Lifestyle Coordinator bought all the music resources from me.

This was not an uncommon response, particularly as I visited facilities in rural NSW.

In some places I have visited however, the activities being conducted were so structured they totally lacked life and spontaneity. It appeared to me they were going through the motions of an activity because it ticked a box, without any consideration for how un-dignified, demeaning and childish they often were.

CASE STUDY 06: AN EXAMPLE OF A STRUCTURED ACTIVITY

In one particular organisation I visited, reception staff were well trained at vetting those entering their facilities. I could not penetrate beyond the front desk, so I never got to speak

to any of their Leisure and Lifestyle staff. I would leave information at the desk for them to pass on to the appropriate staff, but I never received a response from any of them.

On one visit, not realising the facility belonged to that particular organisation, I quite innocently managed get beyond the front desk, as it was not manned when I walked in the door.

On being noticed and questioned as to who I was looking for, I indicated that I wished to speak with the person in charge of Lifestyle and Activities. I was directed to the building next door, where I discovered an activity being supervised by two Leisure and Lifestyle staff. The OT who supervised the Lifestyle programme (often the case in WA aged care facilities) was not present at the time.

The group of residents were painting horseshoes and putting tinsel on them (it was Melbourne Cup time being celebrated). The group were dementia sufferers to varying degrees. There was nice background music playing so it was not obtrusive, **but it was not their music.**

I asked the Lifestyle staff member if I could try one of our CDs to observe their response, to which she consented. Immediately I put a CD from the Blue Book CD Collection in the player, the residents responded with hearty singing.

At that moment the other Lifestyle staff member returned with the OT who appeared quite angry that I had intruded on an activity. Realising this, I removed the CD and put their CD back in the player. As I did there was quite a protest from the residents, with one of them exclaiming, 'Can we have that music?'

The OT responded icily saying, 'We have our own music programme. We don't need your music.'

With that, I picked up the resources and left the building. As I was adding my notes about the visit a lady came bounding across the road yelling at me, 'Do you know you are in breach of security?'

I wondered to myself, whether this was a prison or a home!

I subsequently contacted the head office of this organisation, and the director of Lifestyle was very welcoming. We were in the throes of organising a meeting with a view to me doing a presentation to their group of OTs as she was quite excited about the resources, saying they were looking to review and expand their music programme, when suddenly the communications stopped. I am assuming at that point she had heard from the OT I had encountered when I innocently penetrated beyond the front desk at one of their facilities.

What I found interesting about that visit was the fact that the OT ignored the extent to which the residents were engaging with the music. They were alive with it, yet she was more concerned about the programme being interrupted. However, I sensed the Lifestyle staff understood the resident's response, but they were obviously subservient to their academic oversight. I got the impression this organisation was heavily structured with no room for spontaneity or flexibility.

Western Australia generally has a different system to the rest of Australia in that Leisure and Lifestyle is overseen by an academic, usually an Occupational Therapist. Whilst in some places in Perth I visited it was obvious the Lifestyle staff were subservient to their academic oversight, I found rural WA much like country areas in other states; more relaxed and open.

However, one great company that embraced our resources for all their facilities nationally, employed a qualified Lifestyle person or Diversional Therapist in charge of Leisure and Lifestyle in all their WA facilities, as is generally the case elsewhere in Australia, which, I believe, is how it should

be. Lifestyle staff need to oversee their own profession and not be subject to supervision by anyone arm's-length from the work they do.

UNSUPPORTIVE MANAGEMENT

Music in residential care is generally underutilised. In too many cases and for various reasons, a lot of music used is inappropriate for the clientele being cared for.

Time and time again, when I visit a facility, the Activities and Lifestyle staff are excited by, and can immediately see the value in the music resources I bring with me, however, they don't have a budget for such purchases. Instead, the purse strings are held by facility managers, Directors of Nursing, or other academics in charge, who do not work directly with the elderly in their care.

The following case studies are typical examples of the lack of support Leisure and Lifestyle staff receive:

CASE STUDY 07: INAPPROPRIATE MUSIC

I called into one facility where the Leisure and Lifestyle person was about to start an activity built around music. She was so excited about my resources that she took me to the manager's office straight away, with view to discussing their purchase.

The manager was equally impressed but would not authorise the purchase as she concluded they had a lot of music on hand, most of which had been donated to the facility.

As I was departing the facility, I heard the music begin to play. It was awful; totally inappropriate. I felt for those residents.

Needless to say, the documented activity was designed merely to fulfill a regulatory requirement.

In this example, the Leisure and Lifestyle person immediately recognised the value of the resources but once again, and not uncommon in aged care, the budget considerations became the major factor in the decision-making process.

CASE STUDY 08: PURCHASE APPROVAL REFUSED – RESOURCES RETURNED

The following email was received recently from a Lifestyle Coordinator who purchased all our resources along with 25 songbooks. Because her order was a large one, I only invoiced her for 20 songbooks and donated the other five. She eventually had to return them as she could not get approval for the purchase from the Executive Director. Particularly of late, this is a relatively common problem for Lifestyle staff.

What is interesting about this return is that this facility belongs to a large group where our resources have been widely accepted, even in a nearby town around the same time. So, it appears to be an individual facility management issue.

From: **Lifestyle …….r** <LifestyleFr@.com.au>
Date: Fri, Dec 20, 2019 at 3:55 PM
Subject: RE: Amended ACMR Tax Invoice 1830 attached - ATTN: J….. LC
To: Graeme Pope <graeme@agedcaremusicresources.com>

Hi Graeme,
It makes me really sad to have to say that my ED has told me that she is unable to consider your music program at this time.
Could you ask your representative to drop in and pick it up, or if she is unable to do so I would be happy to drop it around to her.
I want to wish you the best for the Christmas season and a Happy New Year.
Kind regards
J…..
Lifestyle Coordinator

CASE STUDY 09: A HAPPY ENDING FOR CAIRNS LEISURE AND LIFESTYLE STAFF

While in Cairns I experienced pushback from managers in several facilities. The Lifestyle Coordinators realised the value in these resources as tools to support the work they do. The manager in this scenario however, refused to approve the purchase.

In this instance, the Lifestyle Coordinator, well experienced in her field and enthusiastic about the resources, approached her manager who was quite young, and obviously academically well qualified, whose response was that there was plenty of free stuff on the internet. **He was obviously oblivious to how much of her own time she would have to devote to researching and sourcing music for her sessions**.

Fortunately, as I was leaving one of these facilities, I was greeted by a lady who had just retired from 25 years' service as a Lifestyle Coordinator. She was inquisitive about what I was holding. As I showed the CDs and song books to her, she was amazed at the quality and design, commenting that she wished they had been available when she was working in Lifestyle. I told her about the resistance I was experiencing, not from Lifestyle staff, but from managers. I discovered she was a member of the Lions Club in Cairns. As a result of her recommendation the Lions Club funded many sets of these resources, donating them to facilities where I had experienced pushback from management.

Their story can be read on the 'News & Views' page of our website. **A must read**.

Lions and Lionesses see value in Aged Care Music Resources – Aged Care Music Resources

All too often disappointed staff are told they have plenty of music to work with, with no regard to the appropriateness of the selection and whether or not it is music that evokes a positive response in the elderly.

Budget driven managers are not concerned with how much of their own time conscientious staff devote to researching and sourcing music that may be of some relevance to their residents. Nor in fact, do they care that staff are often purchasing resources from their own money.

BULLYING IN THE WORKPLACE

The following case studies are typical of a dictatorial management style where:

1. The authorising person's role is arm's-length from the Leisure and Lifestyle department they head.

2. The valuable experience, knowledge, opinions and needs of the staff working directly with the older people is completely disregarded.

3. The managers **effectively 'filter' what is available to the recreation staff** based on their own judgement, prejudices, and interpretations or instructions from the top.

4. The culture is one of bullying, leading to the loss of knowledgeable and productive staff members from the industry.

CASE STUDY 10: WORKPLACE BULLYING – NEGATIVE OUTCOMES

I called into a facility where the Leisure and Lifestyle staff were having morning tea at a garden table. They were all impressed with the music resources and wanted to add them to their activities toolkit. I was taken to the Director Of Nursing's office where the Lifestyle Coordinator sought approval to purchase them.

The D.O.N. very rudely pointed to me saying she didn't see anyone without a prior appointment. The LC feeling embarrassed and despondent, told me not to worry about it.

I assured her I would worry about it because on the other side of this 'people game' being played are the lives of those I care about. Not being phased by her bullying, I went back to the D.O.N.'s office to request a future appointment. She was contrastingly nice, and suggested I send her an email.

I sent her several emails over the following weeks with no response, so I phoned her. She said the LC had since done an audit of her music resources and decided she had enough.

A few hours later I called the LC and told her about my conversation with the D.O.N. The LC was shocked at the lies being told and resigned from the facility not long after.

CASE STUDY 11: WORKPLACE BULLYING – LACK OF RESPECT

I frequently witness an unhealthy lack of respect between facility managers and their care workers.

In one facility, for example, an excited care worker took me to meet her manager to discuss our resources, after she had witnessed an immediate positive response from the residents when age appropriate music was played for them.

The Lifestyle Coordinator's enthusiasm was shut down as she was dismissed with a wave of the manager's hand, without even hearing what she had to say. I was similarly shown the door. This is not an uncommon response.

CASE STUDY 12: THE PERFECT MODEL

One catholic facility I visited demonstrated the ideal approach and a level of respect between manager and staff I have not witnessed anywhere else.

In this instance, the sister who managed the facility invited me in and asked me to explain who I was and the details of the music resources I had in hand.

Deciding there was value in what I had to offer, she called in her Lifestyle staff and allowed me time to explain the resources to them.

This done, the sister returned and asked the opinions of the staff and how they would use the resources if she were to make the investment.

These staff members were treated with respect by their manager, their opinions sought, listened to, and valued.

Satisfied by her staff members' response, the sister purchased all the resources. She turned and thanked me, not only for bringing the resources to them, but also for my contribution towards improving quality of life for our elders in care.

LEISURE AND LIFESTYLE FOR THE BABY BOOMER GENERATION

I had much to write on the topic of Leisure and Lifestyle requirements for the baby boomers generation, who are now beginning to enter aged care, but to my delight, a greater mind than mine has covered this topic thoroughly.

Jade Gilchrist, Lifestyle Coordinator at the Clifton Aged Care Facility, Queensland has produced a comprehensive paper titled, 'The Impact of The Baby Boomer Generation on Diversional Therapy Practice'. This excellent paper is no doubt already in the hands of the Commissioners. Nevertheless, I have attached it to my submission to ensure its contents are considered in tandem with my own recommendations.

Jade refers to the current generation of eighty and ninety-year old's as the 'Silent Generation'. Until I read Jade's paper, I had always referred to them as the 'Honorable Generation' for all the same reasons. I have seen them put up with so much without complaint. Sadly, many have had to put up with much more than I know my generation (I am a baby boomer of 72 years) would tolerate. While the aged care industry might get away with their treatment of the 'Silent Generation', it does not mean they do not deserve better.

PART 4 IN CONCLUSION

As I hope I have demonstrated, aged care is much more than simply providing shiny facilities which provide for the physical care needs of residents. In an ideal world of aged care, a wholistic approach is needed with a focus on the quality of the workplace environment for staff in addition to maintaining a high standard of care for the residents. The shift towards person-centred care is already well established, but to maintain and strengthen this, we need to focus on the work conditions of those providing the care.

In order to attain this model of excellence, policy and best practice should not be mandated from above, but established through a bottom-up consultation process that draws on the broad experience, knowledgebase, and opinions of the highly qualified staff who work directly with the residents; staff who have a hands-on understanding of the needs of those they care for.

Ideal facility governance should be focused on achieving more positive outcomes at all levels, not only for the residents, but for care staff and other support services. This is a standard best achieved through a Human Factors Training, or Non-Technical Skills, programme. This approach fosters a horizontal management structure where each role is treated with equal respect, through communication and policies that are established to facilitate collaborative teamwork, affecting positive outcomes.

The aim of this approach to aged care governance is to transform the current broad variation in industry culture, traditionally built around a vertical management structure, into a culture based on teamwork. In this framework the various roles involved in aged care are connected synergistically with a focus on achievable, standardised, quality outcomes. This is obtained through an ethos of respect for all staff, demonstrated by giving all an equal say with a right to redress for any issues that may be identified, without fear of recrimination or retribution.

The role of Leisure and Lifestyle staff in residential aged care is core to meeting the spiritual, cultural, social, emotional, leisure and recreational needs of our elders in care. These are essential elements which contribute to their well-being, mental health and quality of life. If Leisure and Lifestyle staff are to properly fulfill their role and meet these needs for those in care, we must have:

- Industry-wide recognition of the Lifestyle profession as respected members of the care team through a shift in workplace culture brought about by the introduction of Human Factors training for all staff.
- Job descriptions with clearly defined boundaries as shaped through input by Leisure and Lifestyle staff.
- The consolidation of the Leisure and Lifestyle role under one umbrella and educational standard, such as that provided by Diversional and Recreational Therapy Australia accreditation.
- The provision of adequate staff to resident ratios.
- A high standard of industry recognised training for caregivers and Leisure and Lifestyle staff.
- A realistic budget to purchase quality, appropriate resources needed to support the work they do, which is managed by the Leisure and Lifestyle staff themselves.

Regulatory focus in aged care needs to not only be on the standards of care for the elderly, but also on the conditions of work for the care staff, particularly those employed in Leisure and Lifestyle. When the staff are appropriately trained, given autonomy and shown respect, the end result is a care home with committed staff who work together as integrated teams to engage with residents and continually seek better ways to manage their individual needs and preferences.

PART 5 RECOMMENDED PROFESSIONALS

Each of the following professionals has informed and influenced my passion for bringing joy to those living in aged care. Equally, I believe, they each have something important to bring to the table regarding improved quality of care for our elders. What is needed is a united front, the objective of which is to establish an elder-care program which focusses on the best outcomes for all.

1. **Professor Henry Brodarty AO**
   MBBS, MD, DSc, FRACP, FRANZCP, FAHMS
   Professor Henry Brodarty is Scientia Professor of Ageing and Mental Health at the University of New South Wales. He is also the Consultant Psychogeriatrician and Head of the Memory Disorders Clinic at the Prince of Wales Hospital New South Wales. He is Director of the Dementia Collaborative Research Centre and Co-Director of the Centre for Healthy Brain Ageing at UNSW.

   We were privileged to have Professor Brodarty present on a training video included with the Musical Armchair Travels music-based resource, which we released in late 2017.

   Music and Memory – Aged Care Music Resources

   In this video clip Professor Brodarty reveals the results of research into the benefits of music for sufferers of dementia. In explaining the fact that different types of memory are stored in separate parts of the brain, he confirms the discovery that music memory is more resistant to decay than either visual or verbal memory.

   On this basis, he advocates for the education of caregivers around psychosocial and non-pharmacological interventions. Professor Brodarty describes the importance of music, its selection, and application in an aged care environment, and the need to train staff in the appropriate choice and use of music as a tool for improving the quality of life of the elderly in care, particularly those with dementia or Alzheimer's. If we can tap into the musical memory of aged care residents through the use of personal preference music, Professor Brodarty explains, we can reduce agitation and aggression as well as lessening apathy and depression, thus decreasing the need for pharmacological intervention.

2. **Professor Felicity Baker**
   PhD, M Mus, B Mus, GC

   Professor Felicity Baker is Professor of Music Therapy and Director, International Research Partnerships for the Creative Arts and Music Therapy Research Unit at the Melbourne Conservatorium of Music, University of Melbourne. She is currently Associate Editor of the Journal of Music Therapy.

   Professor Felicity Baker is overseeing one of the largest research projects into ageing ever conducted. This is a global study involving 1500 participants across nine countries, currently living with dementia. It was through the article, 'How Music Could Revolutionise Dementia Care', that I was introduced to Professor Baker's work. I was fortunate to meet with her early in 2019, to discuss her research into the use of music as medicine to alleviate some of the symptoms associated with dementia, including depression. Her early findings identify music therapy as the key to revolutionising aged care through its ability to reduce levels of depression, agitation and apathy in people living with dementia.

3. **Daniella Greenwood**

BHSc, BA

Daniella Greenwood held the position of Strategy and Innovation Manager at Arcare when I met her. In this role, she was involved in the development of Arcare's Dementia Strategy and the development and implementation of a relationship-centred model of care. Her presentation at a Research Institute for Ageing event in Canada in March 2017, dealt with the topic: Relationships in Long-Term Care: Humanness, Permission and Operational Support. This would be perfect material for use in an NTS training course, which I have recommended be introduced into the aged care industry (p.10)
https://www.youtube.com/watch?v=SndFtWOtRbA&t=364s

In this video presentation Daniella delivers a compelling keynote about how central relationships are in long-term care. She would be an ideal person to consult with regarding reshaping culture change in the aged care industry.

4. **Jade Gilchrist**
   BA, Diploma of Traditional Chinese Painting, Cert IV Training & Assessment, Cert IV Diversional Therapy, Cert IV Small Business Management, Cert IV TESOL, Cert III Community Health Services, Member DRTA

   Currently Jade is the Lifestyle and Volunteer Coordinator at Clifton Community Health Services. With 20 years' experience in Lifestyle in both Australia and China, Jade has worked in various roles in Disability, Aged Care and Education within the Leisure and Health context.

   Graduating in 2014 from USQ as a qualified anthropologist, Jade is now using her research skills to revisit Diversional Therapy Practice in preparation for the entry of the Baby Boomer generation into aged care in the coming decade. Her excellent paper titled, 'The Impact of The Baby Boomer Generation on Diversional Therapy Practice', will be found attached to my submission, to ensure its contents are also considered by the Commissioners.

5. **Ruth Wilson**
   Cert IV Training and Assessment, Life Member DRTA

   In 2006 Ruth Wilson was awarded the Fay Bainbridge Memorial Award in recognition of her outstanding contribution to the profession of Diversional Therapy in Western Australia. From 2001 to 2011, she was employed by a residential aged care provider as a Diversional Therapist, coordinating a team of therapy staff in the provision of quality Leisure and Lifestyle programs to people living in three facilities.

   Ruth is currently employed as a consultant and trainer for AutumnCare Systems, which provides software programs to the aged care industry. When I first set out to market John's music to aged care facilities in July 2003, Ruth was the first Lifestyle professional who saw the potential in our resources. She is not only a presenter on our Musical Armchair Travels program but was also a member of the team of four highly qualified Lifestyle professionals responsible for putting together the content of that program.

6. **Jennifer Inchley**
   Cert IV Diversional Therapy, Advanced Diploma in Aged Care Management, Advanced Diploma in Community Management, Diploma in Health Care Counselling, Diploma in Theology, Cert IV Training and Assessment

Jennifer began her career as an enrolled nurse in 1983 but quickly found her passion lay in palliative care and aged care nursing with a particular interest in the areas of music and activities in aged care. This love of Diversional Therapy was the impetus for a career spanning 20 years as a Lifestyle Coordinator.

Jennifer was also a member of the team of four highly qualified Lifestyle professionals responsible for putting together the content of our Musical Armchair Travels program and has a wealth of experience to draw on.

7. Leonie Bell

BHSc (Leisure and Health)

Leonie commenced work in the health industry in 1975 as a registered nurse, before moving to a career in residential aged care. In 1998 she commenced work as a Lifestyle Manager, a position she held for 21 years until her retirement in 2019.

It was in accepting this position, that Leonie realised she had no qualifications to deliver lifestyle programs and little knowledge of the benefits leisure held for the well-being of residents living in permanent aged care. Thus, she took it upon herself to study for a Bachelor of Health Science (Leisure and Health), in order to do justice to this important role. The knowledge she gained through study and her experience of working with the elderly has informed Leonie's work and helped her to advocate for the provision of quality lifestyle/activity programs for residents in the aged care environment.

Leonie was also a member of the team of four highly qualified Lifestyle professionals responsible for putting together the content of our Musical Armchair Travels program.

8. Anne Kelly

Anne Kelly is a registered nurse and a subject matter expert on the application of Montessori principles for Aged Care and Dementia. She is currently the Director of Montessori Consulting in Australia. She also holds qualifications in Post Graduate Dementia Management, Assessment and Workplace Training and Dementia Care Mapping.

Anne has worked extensively in aged and dementia care, both residential and community based, for the past 38 years. She is chair of the Association of Montessori Internationale Scientific Pedagogical committee on Montessori for Dementia and Ageing. She is considered both an Australian and world leader in Montessori Methods for aged care and dementia. Her work takes her across Australia and around the world, providing training, mentoring and consultation to care communities developing Montessori methods into practice.

Anne's first book, published in 2017, Forgetfulness, Feelings and Farnarkling, examines where aged care has come from, where we are now and where we need to be. This work is very relevant to any inquiry into aged care practice.

9. Carol Digna

Carol boasts 16+ years in the aged care industry, a career which was driven by her passion to support our elders in care to live their best life while maintaining dignity. Her letter, printed with her permission on page 12 of this submission, reveals her disappointment and frustration working in an industry that does not give Lifestyle the value and level of

importance it warrants, in order to engage aged care residents in 'truly meaningful and activity', delivered by 'highly trained and respected members of the care team'.

10. Diversional and Recreation Therapy Association

The DRTA are a body I hold in high regard and which I commend to this inquiry as an exemplar to the aged care industry, in terms of the level of training and education we should be demanding for those engaged in Lifestyle. If all staff in Leisure and Lifestyle roles were amalgamated under the umbrella of Diversional Therapists, their roles would be clear, and they would be governed by one body and one standard of education.

I support the Diversional and Recreation Therapy Association and am a regular attendee at their conferences. I presented at the DRTA Conference in New Zealand last August and have been invited to present again this year.