6 August 2004

DAA Submission

Senate community affairs reference committee inquiry into aged care

The Dietitians Association of Australia (DAA) welcomes the opportunity to comment on the Senate community affairs reference committee inquiry into aged care.

Organisation: Dietitians Association of Australia
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DAA is the national Association of the profession, with Branches in each State and Territory. DAA represents approximately 2600 members. Dietitians are employed in a wide variety of work areas including clinical dietetics, public health and community nutrition, education, private sector, government, research and industry. DAA is a leader in nutrition and advocates for better food, better health, better living for all.

DAA welcomes the opportunity to contribute to this senate reference committee inquiry. Members of DAA's National Nutrition and Disability Interest Group, Victorian Rehabilitation and Aged Care Interest group and other members who are experienced in different aged care settings have contributed to this submission. DAA members with expertise in this area of practice would welcome the opportunity to contribute further to this inquiry.

Please contact either Ruth Kharis or Sue Cassidy (02 6282 9555) for further information and clarification of our submission.

Executive Summary

Poor or inadequate nutrition in older people or younger people with a disability presents a significant health risk that has proven to be very common in aged care facilities and in community settings (Azad et al 1999, Potter 1995, Thomas et al 2002, Thomas et al 1991). The cost to the Australian community of increased morbidity and mortality that accompanies poor or inadequate nutrition can be reduced by improvements in aged care services with the objective of improving nutritional care.

The Dietitians Association of Australia (DAA) recommends that within any rearrangements of aged care funding by the Commonwealth Government, funds are specified for the nutrition assessment and monitoring of individual people in residential care who have been assessed as being at nutritional risk; that the risk assessment process be regularly carried out on admission and at least 6 monthly, using proven risk assessment tools and processes; and that the services of nutritional assessment and monitoring be carried out by qualified Dietitians who are eligible for full membership of the Dietitians Association of Australia. DAA further recommends that food services in residential care facilities be assessed on a regular basis for

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conformity to a minimum set of standards that include menu and food provision standards, food safety standards and staff training standards.

DAA believes that there should be a coordinated approach at a national level, to ensure that all older Australians, whether they are free living in the community, in transitional care or in residential care, have equity of access to nutrition advice and care.

a) the adequacy of current proposals, including those in the 2004 Budget, in overcoming aged care workforce shortages and training;

Nutrition and dietetic services for older people are an integral part of managing and funding residential care services, transitional care and hospital based rehabilitation. Some of the roles of dietitians in residential care are indicated in figure 1. The National Strategy for an Ageing Australia (Andrews 2001) clearly identifies good nutrition as an important factor in healthy ageing. The provision of adequate nutrition and hydration are essential human rights, which are clearly demonstrated and supported by Article 25 of the Universal Declaration of Human Rights (General Assembly of the United Nations 1948):

> "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."

Implementation of the Well for life program (Victorian Department of Human Resources 2003) also indicates useful Victorian examples of action learning processes use in residential care.

Figure 1 Some of the roles of dietitians in residential care

ROLES OF DIETITIAN IN RESIDENTIAL CARE in RELATION TO ACHIEVING STANDARDS 2.10 AND 4.8:

·Develop and review policies and procedures in relation to meeting food and nutrition needs of residents
·Health promotion and preventive programs
·Develop and implement nutrition risk screening and intervention
·Assessment and ongoing management of individual residents' food, nutrition, hydration and special dietary needs
·Manage special needs of residents who require tube feeding and transitional feeding
·Food service assessment
·Menu planning and review, including catering for those with special diets and groups with specific cultural and religious needs
·Recipe development and standardisation
·Staff training and support with ensuring latest resources are available
·Resident satisfaction surveys
·Continuous quality improvement in relation to meeting Standards 2.10 and 4.8

Dietetic contact time with the resident and the facility staff to provide quality Dietetic services will vary according to the individual resident's clinical condition. Dietitians need to consult with catering or nursing staff, other allied health staff and the residents' families. These forms of service provision are all equally important and should be recognised as such by appropriate funding. Weekly or twice weekly reviews may be necessary for residents who are not medically stable. Conversely, less frequent reviews may be required for others for

maintenance of care. The funding system does not appear to allow for these differences in approach and therefore sets up a disincentive for accessing the professional services of a Dietitian. Furthermore, current funding and accreditation systems do not support the use of a Dietitian in health promotion or preventive health programs.

The funding of professional dietetic services is not clear to those Dietitians working in the residential care area. The involvement of Dietitians in residential care varies between homes. It would be helpful to have more specific information on how the funding is allocated to Dietetics. DAA therefore seeks clarification on the RCS funding and global funding and how these determine the amount and frequency of Dietetic time employed.

The 2004-2005 Federal Budget includes a range of measures within a $2.2 billion package, which includes the payment of more competitive salaries and training for nursing and other staff in residential aged care facilities. DAA recommends that these funds specifically allow for education and training of the aged care workforce in the area of nutrition risk screening, documentation and management of those found to be at risk. The aged care workforce needs to be appropriately trained by qualified professionals, including Dietitians. DAA would like to see the recent Victorian Department of Human Resources project, Well for Life, which aims to improve nutrition and physical activity opportunities for residents in aged care facilities, rolled out nationally.

(b) the performance and effectiveness of the Aged Care Standards and Accreditation Agency (ACSAA) in: assessing and monitoring care, health and safety,

(i) assessing and monitoring care, health and safety

- Over recent years, the ACSAA has given increasing attention to nutrition standards for care of residents in aged care facilities. This is supported by the fact that more Dietitians are now employed directly by facilities compared with a few years ago. Dietitians are also called to assess various aspects of care in response to a less than favourable ACSAA report. In recent years ACSAA processes have significantly improved standards in provision of food and nutrition. However, sometimes ACSAA reviews appear to be variable between homes and inconsistent with the principles implied in the Standards and Guidelines in 2.10 Nutrition and Hydration and 4.8 Catering, Cleaning and laundry services. Different aspects of care, health and safety might be focussed on during site visits and interviews. The evaluation of nutritional care by accreditors is highly variable and inconsistent. In addition, the Standards and Guidelines for Residential Aged Care Services (Commonwealth Government, 1998) provide only general statements about nutrition and hydration.

- The interpretation of Standard 2.10 usually depends on the knowledge of the person who is determining when dietary advice is necessary, rather than on evidence-based guidelines for best practice. Examples of inadequate nutrition provision that our members have found include:

    - a nursing home giving a person who needed enteral tube feeding a cheaper and inferior nutritional formula than the one that was prescribed

    - inadequate nutrition given via an enteral feeding tube because staff were unaware of the individual parameters used to assess nutritional requirements – they used a "one size fits all" approach

- incorrect food texture and fluid consistency given to a person with a swallowing problem following stroke, thereby increasing their risk of aspiration pneumonia and subsequent hospital admission or death

- inadequate attention given to appropriate level of fluids to achieve hydration for residents.

The main barriers to using a Dietitian seem to be a lack of awareness of nutrition and lack of policy and procedures on how to most effectively use the services of a Dietitian in a timely manner. Other barriers include lack of funding and the fact that nobody seems to know how much is allocated to Dietetic services out of the total funding package for allied health. Our experience is that some homes regularly access dietetic services and others do not.

DAA would recommend the following to assist in a review of residential care by ACSAA:

1. Ensure that ACSAA insist on evidence that people providing dietetic services in residential aged care are full members, or eligible for full membership of the Dietitians Association of Australia.
2. Further define or standardise the interpretation of the Standards and Guidelines in relation to inclusion of dietetic services and provision of food and nutritional care.
3. Encourage Dietitians to undergo formal training to become accredited assessors for the residential aged care industry.
4. And/or, encourage ACSAA to consult with the profession on continuous improvement in assessment and review processes and interpretation of the Standards and Guidelines.
5. That an evaluation be conducted of how Medicare Plus may be applied by General Practitioners providing services to nursing home residents so that dietetic service for individual residents could be sought.
6. That systems are put in place through the accreditation process to ensure money allocated for dietetic services are spent on dietetic services and are not diverted elsewhere.

(ii) identifying best practice and providing information, education and training to aged care facilities

The ACSAA could better assist facilities in identifying and implementing best practice food and nutrition services to residential aged care facilities. To do this the agency itself would benefit from input from Dietitians regarding the nutritional issues of older Australians in residential aged care (refer to recommendations above). The ACSAA could consider the use and promotion of the "Well for Life" Nutrition Help Sheets (Victorian Department of Human Services, 2003) and the "Best Practice Food and Nutrition Manual for Aged Care Facilities" (Central Coast Health, 2004) as part of their assessment resources. Dietitians have been integral in the development of these valuable resources for facilities. Dietitians are the most appropriate nutrition experts to assess the nutritional status and nutritional needs of residents. DAA advocates for the involvement of Dietitians in best practice development, education and training.

(iii) implementing and monitoring accreditation in a manner which reduces the administrative and paperwork demands on staff;

DAA would be interested in working with the ACSAA in the development of a series of nutrition related outcome measures for residents. The recent Draft National Framework for Documenting Care in Residential Aged Care Services (Department of Health and Ageing, 2004) commenced the process of reviewing and rationalising processes for collection of

nutrition information on residents. Unfortunately, this document still requires considerable refinement if it is to achieve real savings in time for facilities, while improving assessment, intervention and review processes for residents.

DAA suggests further review and development of admission and assessment documents to ensure better recording of nutrition risk, nutrition assessment, documentation of appropriate interventions and monitoring of progress, towards achieving quality nutrition care with meaningful, but minimal documentation. Many DAA members have experience and expertise in these areas and would provide valuable consultation and advice in such a review process.

(c) the appropriateness of young people with disabilities being accommodated in residential aged care facilities and the extent to which residents with special needs, such as dementia, mental illness or specific conditions are met under current funding arrangements;

DAA believes it is inappropriate to place young people in residential aged care facilities as stimuli relevant to their individual capabilities/difficulties enhances their quality of life. Many young people with a disability will respond to different environmental stimuli and aged care facilities are not set up to provide this. Residences specifically targeting younger people and their needs will provide a better quality of life for people with disabilities.

When an assessment of the care needs of a young adult leads to an outcome of moving the person into residential care there are few choices available. This is particularly so since the advent of deinstitutionalisation. Specialised care within nursing homes has developed for certain medical conditions including dementia but has not developed for age groups of people. Placing a young person with a disability amongst the aged, severely limits their opportunities for social interaction with their own community peer group, limits language skills development and potentially institutionalises them as "old before their time". A DAA member has observed a young person with Downs Syndrome regress in their eating and drinking skills and general self care skills after placement in an aged care residential facility. The regression was apparently due to the environment of care within the residence rather than a general medical or mental deterioration in the person themselves.

Best practice guidelines for those in aged care are quite different to the best practices for the young with physical and/or mental disabilities particularly with respect to safe and nutritious eating (Department of Ageing, Disability and Home Care, DADHC 2003). There can be specific physical problems directly associated with the function of eating that require an individualised program so the person can eat an adequate amount of food in a safe manner. Staff qualifications required for the caring of these two groups is quite different in some aspects of care. The young person's mental age if they have an intellectual disability may not coincide with his/her physiological age. This can result in a need for a greater level of staff involvement than is generally required for the aged care community. In NSW the DADHC has recently implemented a risk assessment tool called the Nutrition and Swallowing Checklist. This has identified many clients with nutrition and swallowing problems that had not previously been recognised by their carers and were undiagnosed. By placing these clients in nursing homes such initiatives as the Nutrition and Swallowing Checklist would be lost unless specific requirements were written into accreditation standards.

(d) the adequacy of Home and Community Care programs in meeting the current and projected needs of the elderly;

DAA is concerned with the combination of Federal and State Government funding of HACC services, and the ability of each state and local government area to decide what mix of services to fund. This combination results in variability and inconsistency between states and

local government areas in the services provided/available through HACC programs. It also contributes to inequities in health care and service availability to aged clients. For example, NSW has virtually no community based dietetic/nutrition service compared with Victoria where there are several dietitians employed through HACC funds. Even with this, Victorian HACC Dietitians still consider the area significantly under-resourced. This is evidenced by long waiting lists in many areas in which HACC Dietitians are funded, and a lack of HACC funding altogether in some regions. There is an increasing emphasis on moving older people out of the hospital system earlier and into the community for ongoing management, which includes the need for ready access to specialist dietetic services. In the document Improving Care for Older People: A Policy for Health Services, the Victorian Department of Human Services (2003) recognises the significance of nutrition as a care issue, and the need for ongoing care. Home and community based dietitians are the best-qualified health care practitioners to advise and monitor clients at nutritional risk.

An additional concern regards the manner in which HACC funded Dietetic services are funded. In Victoria, Dietetic Services fall under an Allied Health umbrella. Agencies who receive HACC Allied Health funding may in fact provide no Dietetic Services or significantly less Dietetic services than other Allied Health services such as Podiatry or Physiotherapy. One solution to this problem would be for funding bodies to specify the type of Allied Health services to be provided, thus ensuring that there was equality in the distribution of funds between different Allied Health professions. Almost all HACC Dietetic positions in Victoria are funded to provide only one to one direct client care (unit cost funding). There is little or no allocation for Service System Resourcing, which would enable Dietitians to play a broader role, in areas such as the education of Assessment Officers, Personal Care Attendants, other Allied Health professionals and enable them to form closer working relationships with hospitals, Meals on Wheels providers and other community based services.

The HACC program has commenced initiatives towards improving recognition by HACC service providers of the risks of malnutrition in their clients. An initiative of the Victorian Department of Human Services, Identifying and Planning Assistance for Home Based Adults who are Nutritionally at Risk (2001) began in Victoria but needs to be systematically introduced in each State and Territory. Improved nutritional care can be facilitated in many ways including providing carer information and education, meal preparation assistance, meal provision or supplementation. One component of a multi-strategic approach is professional nutritional assessment and development of nutrition care plans for clients at high nutritional risk. An essential element of a comprehensive approach is ensuring that relevant professional Dietetic services are available to respond to referrals.

In 2004, the Victorian Department of Human Services funded seeding grants across the State to implement Well for Life process, and develop resources to enhance nutrition and physical activity opportunities in residential care and further the development of the process to address similar issues in community based programs like Planned Activity Groups and home care services. DAA believes that there should be a coordinated approach at a national level, to ensure that all older Australians have equity of access to nutrition advice and care.

(e) the effectiveness of current arrangements for the transition of the elderly from acute hospital settings to aged care settings or back to the community.

Processes need to ensure appropriate nutrition assessment and management, including continuity of care for older people throughout the healthcare system – from acute, to subacute, rehabilitation or interim care, to community care or residential care settings. This is likely to require higher input of Dietetic services at all levels in health care where older people are more in need of specialised knowledge and skills of Dietitians. There needs to be better coordination of services between these phases of care, in a consistent manner across

Australia. Integral in this process is ensuring that there are sufficient numbers of community funded Dietitians.

A recently released document in Victoria has defined benchmark levels for Allied Health Services in Rehabilitation (Allied Health Rehabilitation Consultative Committee 2004). This document is designed to assist organisations in establishing appropriate levels of allied health staffing and could be used by other States. It is important that clients in residential care, community based and hospital-based rehabilitation all have equal access to dietitians. For rehabilitation services DAA understands dietitians are not currently listed as core services, compared to other allied health services.

The Home Enteral Nutrition Service program in Victoria provides funding for formulae and equipment, however does not fund Dietetic services which are required to reassess and monitor home based clients on enteral feeds. Funding for enteral formulae is not available in NSW. DAA believes this inequity between states in funding of home enteral nutrition products should be redressed.

In Victoria, there are a small number of Dietitians employed in Rehabilitation in the Home, Home Based Allied Health, Transition Support Program, Hospital In The Home, and Post Sub-Acute Care Home Interim Care. Again, waiting lists held by these services would indicate that this is a significantly under-resourced area of health care. DAA suggests that these models of care be expanded and implemented into other states as a way of supporting earlier hospital discharge.

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