



March 2010

**Submission from the Dietitians Association of Australia
to the Department of Health and Ageing
Review of the Aged Care Funding Instrument**

About DAA

The Dietitians Association of Australia (DAA) is the national association of the dietetic profession with over 4000 members, and branches in each state and territory. DAA is a leader in nutrition and advocates for better food, better health, and better living for all. DAA has a role to advocate for broad public health responses to the prevention and management of nutrition related health issues. DAA provides accurate and practical information to Australians and supports members in their professional practice.

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Context

The DAA is pleased to provide comment on the Aged Care Funding Instrument (ACFI) review. DAA recognise that “the ACFI is a funding tool, based primarily on the resident’s need for care or dependency” and not a comprehensive care planning tool. DAA is aware that the Aged Care Accreditation Standards operate essentially in tandem to the ACFI where the ACFI addresses individual needs and the Accreditation Standards address systemic needs in residential aged care facilities.

DAA presents this submission focusing on two of the ACFI Review’s terms of reference:

- the impact of the introduction of the ACFI on access to appropriate care.
- the design of the ACFI to determine whether the ACFI properly recognises the roles of care providers in relation to the delivery of care needs, including the role and scope of practice of enrolled nurses and allied health professionals.

Underpinning this submission is a strong evidence base supporting nutrition care appropriate for the residential care setting. Please see the recently published and DAA endorsed ‘Evidence Based Practice Guidelines for the Nutritional Management of Malnutrition in Adult Patients Across the Continuum of Care’¹ available from the DAA website at <http://www.daa.asn.au/index.asp?pageID=2145872887>.

Recommendations for ACFI review

- DAA calls for changes to the current ACFI to better recognise the important supportive role and significant time required of nursing and care staff to adequately meet the daily needs of residents in aged care facilities. Particularly in relation to staff weighing residents, monitoring oral intake, providing feeding assistance and preparing special foods. Dietetic services also need to be better recognised as complex care especially in the areas of chronic wound management, skin integrity and unintentional weight loss. Specific edits to the ACFI are detailed in this submission.

Further recommendations to improve nutrition outcomes in Residential Aged Care Facilities

- That Commonwealth funding allows and supports Accredited Practising Dietitians (APDs) to work in a proactive manner in residential aged care facilities.
- That all residential aged care residents are screened by the dietitian to identify those at risk of unintentional weight loss on admission and then at regular intervals.
- That APDs are appropriately funded to implement systems that allow for routine nutrition status screening, and to assess and monitor individual residents identified as being at nutritional risk.
- That significant unintentional weight loss is recorded across all approved RACF providers as an essential quality indicator.
- That the Commonwealth monitor nutritional status in residential aged care facilities and report on prevalence of malnutrition.
- That the Department of Health and Ageing review of the Accreditation standards recognises and supports the implementation of national menu planning standards for residential aged care settings.
- That Commonwealth funding recognises and supports dietitians' role to perform systemic level activities such as facility wide menu assessment and planning as well as quality improvement projects.
- That the Accreditation standards ensure RACF staff are trained in appropriate feeding techniques and accurate weight measurements.

The impact of the introduction of the ACFI on access to appropriate care

DAA believes that the current ACFI fails to recognise key tasks that are required of nursing and care staff to adequately support the nutritional health of residents. Below we elaborate on the prevalence and impact of malnutrition in RACFs, the issues faced by Accredited Practising Dietitians, the case for screening and models of care for consideration.

Malnutrition is a problem in residential aged care

Nutrition care is relevant across the continuum of ageing (from infancy to geriatric). It is well documented and well known that good nutrition and physical activity is essential for preventing many acute and chronic health issues experienced by Australians². Access to food and good nutritional health should be a fundamental human right³. Nutrition status largely determines quality of life, independence and overall health of older adults in residential aged care facilities⁴

Malnutrition is commonly defined^{1,5} as deviations from a normal nutritional state including both excess and deficiency states of energy, protein and other nutrients. For the purpose of this submission, malnutrition refers solely to protein–energy under nutrition.

The prevalence of malnutrition tends to increase with age and is a widespread issue in the Australian residential aged care population. Prevalence of malnutrition in residential aged care facilities has recently been reported as high as 50%^{5,6}.

Evidence^{4,7,8,9,10} shows that unintentional weight loss places individuals at greater risk for clinical complications such as increased risk of falls and fractures; increased risk of osteoporosis, infections and pressure ulcers; increased rates of depression; decreased mobility, morbidity and mortality; delayed healing from acute episodic events, prolonged and increased frequency of hospitalisation and decreased quality of life. Such complications put great strain on our hospital systems and aged care facilities and places higher costs on local communities.

The prevalence of obesity and its consequences has contributed to a lack of recognition of malnutrition. Obese individuals can lose weight unintentionally and become malnourished. These individuals should not be ignored when attempting to identify persons at nutritional status risk.

To proactively protect individuals against unintentional weight loss and subsequent risk of adverse clinical outcomes individuals at risk need to be detected. Implementing routine nutrition screening is the optimal way to ensure malnutrition does not go undetected..

There are significant cost implications of malnutrition prevalence on residential aged care facilities. Malnourished residents are dependent on increased amounts of health care staff time.

Current issues for Accredited Practising Dietitians in the residential aged care sector

Common issues seen by dietitians working in RACFs include:

- a prevalence of residents suffering unintentional weight loss and malnutrition. Unintentional weight loss in an individual and the consequent decline in general health can often be prevented through evidence based dietetic intervention^{10, 11, 12, 13}. It is concerning that APDs are not routinely supported to join clinical teams.
- simplistic nutrition supplement prescribing systems are often in place which can result in significant costs to RACFs through supplying unnecessary products to residents in a bandaid, broad brush approach to attempt to reverse chronic weight loss. Appropriate interventions and strategies implemented with food service can reduce the reliance on costly nutritional supplements.
- a lack of appropriate funding for RACF to access a range of Accredited Practising Dietitian services.
- a lack of proactive monitoring systems such as routine nutrition risk screening. Currently, much dietetic input is reactive. APDs are often called in once an individual has already lost a significant amount of weight and or may already be severely malnourished. Some dietitians have had success in developing systems with residential aged care facilities (RACFs) to identify risk of malnutrition early thereby

improving clinical outcomes, quality of life for residents and saving costs of care longer term.

- a lack of appropriate referrals to APDs for timely assessment and individualised nutrition intervention.
- a lack of national menu planning standards for the residential aged care setting. Agreed standards would help aged care providers deliver nationally consistent, appropriate diets to residents and ensure equity for aged care residents in Australia.
- inadequate funding of RACFs to provide residents with appropriate thickened fluids and oral nutrition supplements.
- RACF currently receive funding to support residents requiring nasogastric (NG) or percutaneous endoscopic gastrostomy (PEG) feeding via Medicare however they do not receive funding for residents requiring oral nutrition supplements to meet their nutritional requirements.
- Residents who require assistance with meals and fluids often do not receive consistent, appropriate assistance from RACF staff to eat.

There is good evidence to support nutrition screening

There is likely to be both economic benefits and health benefits (clinical outcomes and quality of life).

The recently published *Evidence Based Practice Guidelines for the Nutritional Management of Malnutrition in Adult Patients across the Continuum of Care*¹ (the Guidelines) highlight the impact of malnutrition and provides guidance to health care providers regarding affordable detection systems including routine malnutrition screening. The Guidelines report that:

- There is a high prevalence of malnutrition (in the order of 40-70%) in Australian residential aged care setting¹.
- Malnutrition is associated with adverse clinical outcomes and costs¹.
- Malnutrition is both under-recognised and under-diagnosed¹.
- Routine screening for malnutrition should occur in the residential aged care setting to improve the identification of malnutrition risk and enable nutritional care planning¹.

The Guidelines also identify validated tools for both malnutrition screening and assessment. Malnutrition screening tools that have been validated for use in the residential aged care setting¹ include:

- Mini Nutritional Assessment-Short Form (MNA-SF) older adults only
- Malnutrition Universal Screening Tool (MUST)
- Simplified Nutrition Appetite Questionnaire (SNAQ)
- Simple Nutrition Screening tool (CNAQ)

Malnutrition Assessment tools are used by dietitians to diagnose malnutrition. The Subjective Global Assessment (SGA) and The Mini Nutritional Assessment (MNA) are validated assessment tools appropriate for use in the residential aged care setting¹.

Early detection of under-nutrition (i.e. screening) should lead to early dietetic intervention. This early action should have an impact on cost savings because consequent morbidities associated with poor nutritional status are prevented.

Models for consideration

Victoria

Victoria is leading the way in the public sector with benchmarking of quality indicators which includes monitoring of unintentional weight loss. There is potential in replicating this model across Australia. This model requires facilities to report on unintentional weight loss at regular intervals as an essential quality indicator¹⁴. Nutrition screening is in place to facilitate this reporting as well as a referral pathway to the dietitian. In Victoria, dietitians are funded to provide services to RACFs which includes clinical interventions and systemic approaches to care and food service. Nursing staff are trained to record accurate weights, have appropriate equipment (eg. weigh chairs/ lifters) and are provided with inservice training by the dietitian.

DAA has developed a flowchart to demonstrate the breadth of nutrition services required in a RACF. See Appendix I.

Residential Nutrition Management Reviews (RNMR)

DAA strongly calls for routine and cyclic nutrition screening to be implemented across the aged care industry.

Pharmacists are currently funded to undertake regular medication reviews (RMMR) of aged care residents (see Appendix II). Using a similar model, Accredited Practising Dietitians could be funded to coordinate routine nutrition screening processes and undertake nutrition assessments. See Appendix III for a summary on how this system could be implemented.

The design of the ACFI to determine whether the ACFI properly recognises the roles of care providers in relation to the delivery of care needs, including the role and scope of practice of enrolled nurses and allied health professionals

DAA believes it extremely important that all health professionals practice professionally and ethically within their scope of practice. The ACFI recognises specific allied health professionals in some parts but in other parts (specifically the 'Requirements' under the Complex Health Care) is more generic. This could be improved by detailing specific allied health professionals more accurately where relevant. The role of Accredited Practising Dietitians and the specific recommended changes to the ACFI are detailed below.

Accredited Practising Dietitians play an important role in aged care

Accredited Practising Dietitians (APDs) are recognised professionals with the qualifications and skills to provide expert nutrition and dietary advice. APDs have the expertise to both diagnose nutrition related issues (malnutrition; chronic weight loss) and advise on interventions to prevent and treat nutrition related issues.

APDs work in the aged care sector across Australia. There is a variety of dietetic input currently across Australia in the residential aged care setting. APDs may undertake the following activities:

- Development of streamlining and systems based approaches eg. regular weight monitoring, screening, referral pathways, intake reporting,
- Individualised dietetic interventions after appropriate referrals made via risk screening

- Participation in team care meetings with care staff, GPs and other allied health to discuss and develop plans for individual resident care.
- Monitoring of weight status over time
- Assistance to residential care facilities to order appropriate nutritional supplements for specific nutrition related issues, liaison with Dept Veteran Affairs and/or supplement suppliers.
- Regular review of individuals with NG or PEG feeding regimens.
- Education of RACF kitchen staff on recipe formulation (eg. high energy and modified texture), meal waste reporting,
- Education of nursing staff on nutrition screening, height and weight measuring techniques, dietary intake monitoring, appropriate nutrition supplement use , modified texture
- Work with RACFs to meet accreditation requirements related to nutrition / food service
- Menu assessment and evaluation
- Quality Improvement projects, eg. evaluation of nutrition interventions and screening processes; plate wastage surveys; resident food satisfaction surveys

Some common examples of conditions where an APD may be referred to provide individualised dietetic intervention:

- Unintentional weight loss/ under-nutrition
- Pressure ulcers / Chronic wound management
- ensuring nutritional adequacy of texture modified diets
- Overnutrition/ obesity related issues (specifically an issue for care staff when washing, dressing & performing other ADLs; implications for RACFs equipment as well such as toilet seats; dining room chairs; beds; walkers etc)
- Hydration issues
- Residents with diabetes (type 1 or type 2)
- Residents requiring specific meal plans for specific conditions such as kidney disease; coeliac disease, food allergies; lactose intolerance; chronic constipation or other bowel/gut issues
- Pressure ulcers/ Chronic wound management
- Feeding regimens for NG/ PEG tubes
- Residents with Parkinsons disease and other motor neurone diseases to cope with medication regimens and related food-nutrient interactions
- Strategies to assist residents with dementia related symptoms and behaviours
- Bowel function irregularity.

Ensuring palliative care residents are attended to as necessary, including consulting with family of resident as per team plan.

Specific recommendations for changes to the current ACFI

Proposed changes to ACFI are shown in the below table on the right hand side. Specific additions are shown in italics and deletions shown with a line through the text.

ACFI 1 Nutrition (Activities of Daily Living domain):

<i>Current ACFI Checklist</i>	<i>Proposed New ACFI Checklist</i>
Nutrition Checklist	Nutrition Checklist
<p>1. Readiness to eat Supervision is:</p> <ul style="list-style-type: none"> Placing utensils in the residents hand. <p>One-to-one physical assistance is required for:</p> <ul style="list-style-type: none"> Cutting up food OR vitamising food. 	<p>1. Readiness to eat Supervision is:</p> <ul style="list-style-type: none"> Placing utensils in the residents hand. <p>One-to-one physical assistance is required for:</p> <ul style="list-style-type: none"> Cutting up food OR vitamising food. <i>OR Preparation of thickened fluids or high energy high protein foods or drinks for individual residents</i>
<p>2. Eating Supervision is:</p> <ul style="list-style-type: none"> Standing by to provide assistance (verbal and/or physical) OR providing assistance with daily oral intake when ordered by a dietitian for a person with a PEG tube. <p>One-to-one physical assistance is required for:</p> <ul style="list-style-type: none"> Placing or guiding food into the residents mouth for most of the meal. 	<p>2. Eating Supervision is:</p> <ul style="list-style-type: none"> Standing by to provide assistance (verbal and/or physical) OR providing assistance with daily oral intake when ordered by <i>an Accredited Practising dietitian</i> for a person with a PEG tube. <p>One-to-one physical assistance is required for:</p> <ul style="list-style-type: none"> Placing or guiding food into the residents mouth for most of the meal. <i>Recording a food intake chart when ordered by an Accredited Practising Dietitian.</i>
	<p>3. Weighing <i>Supervision is:</i></p> <ul style="list-style-type: none"> <i>Weighing a resident with a mobile weigh scale or assisting resident whilst standing on scales AND recording weight in weight book.</i> <p><i>One-to-one physical assistance is required for:</i></p> <ul style="list-style-type: none"> <i>Weighing a resident on a lifter requiring at least two care staff members to perform this task AND recording weight in weight book.</i>

ACFI 12 – Complex Health Care domain:

Current ACFI Checklist			Proposed New ACFI Checklist		
Score	Complex health care procedure	Requirements	Score	Complex health care procedure	Requirements
3	Complex skin integrity management for residents with compromised skin integrity who are confined to bed and/or chair or cannot self ambulate. The management plan must include repositioning at least 4 times per day.	1.Directive [registered nurse or medical practitioner or allied health professional] AND 2. Skin integrity assessment	4	Complex skin integrity management for residents with compromised skin integrity who are confined to bed and/or chair or cannot self ambulate. The management plan must include repositioning at least 4 times per day. <i>AND the management plan must include nutrition assessment and care plan developed by an APD</i>	1.Directive [registered nurse or medical practitioner or allied health professional] AND 2. Skin integrity assessment
3	Management of chronic wounds including varicose and pressure ulcers and diabetic food ulcers	1.Diagnosis of ACCR AND 2. Directive [registered nurse or medical practitioner or allied health professional] AND 3.Wound assessment AND On request: record	4	Management of chronic wounds including varicose and pressure ulcers and diabetic food ulcers <i>AND the management plan must include nutrition assessment and care plan developed by an APD</i>	1.Diagnosis of ACCR AND 2. Directive [registered nurse or medical practitioner or allied health professional] AND 3.Wound assessment AND On request: record
3	Management of special feeding undertaken by an RN, on a one-on-one basis, for people with severe	1.Directive or ACCR AND 2.Directive [registered nurse or	3	Management of special feeding undertaken by an RN, on a one-on-one basis, for people with severe	1.Directive or ACCR AND 2.Directive [registered nurse or

	dysphagia, excluding tube feeding. Frequency at least daily.	medical practitioner or allied health professional] AND 3.Swallowing assessment		dysphagia. <i>Also those with poor upper limb immobility, advanced dementia, blindness.</i> excluding tube feeding. Frequency at least daily.	medical practitioner or allied health professional speech pathologist or APD] AND 3.Swallowing assessment by speech pathologist
			3	<i>Complex nutrition management and practice undertaken by an APD. This will involve contribution to nutrition care plan and or case conference specifically for reporting results of nutrition screening AND ongoing management at least daily of nutrition care plan AND ongoing case conferencing regarding APD review at least monthly.</i>	
				<i>Management of unintentional weight loss through regular recording of weights each quarter AND evidence of nutrition screening AND evidence of nutrition care plan</i>	<i>Directive [registered nurse or medical practitioner] AND 2 Nutrition assessment by APD</i>

DAA also recommends that the use of the generic term ‘allied health professional’ is reconsidered so that the appropriate specific allied health professional is indicated. For example, under Complex Health Care regarding ‘special feeding undertaken by an RN, on a one-to-one basis, for people with dysphagia, excluding tube feeding’. One of the

requirements is a 'Directive from an RN, medical practitioner or allied health professional'. The allied health professional appropriate would be a speech pathologist or an APD. Another example on the current checklist, is regarding complex pain management. Therapeutic massage is not within the scope of practice of an APD. Hence, allied health professions that do have this intervention in scope should be listed rather than the use of 'allied health professional'.

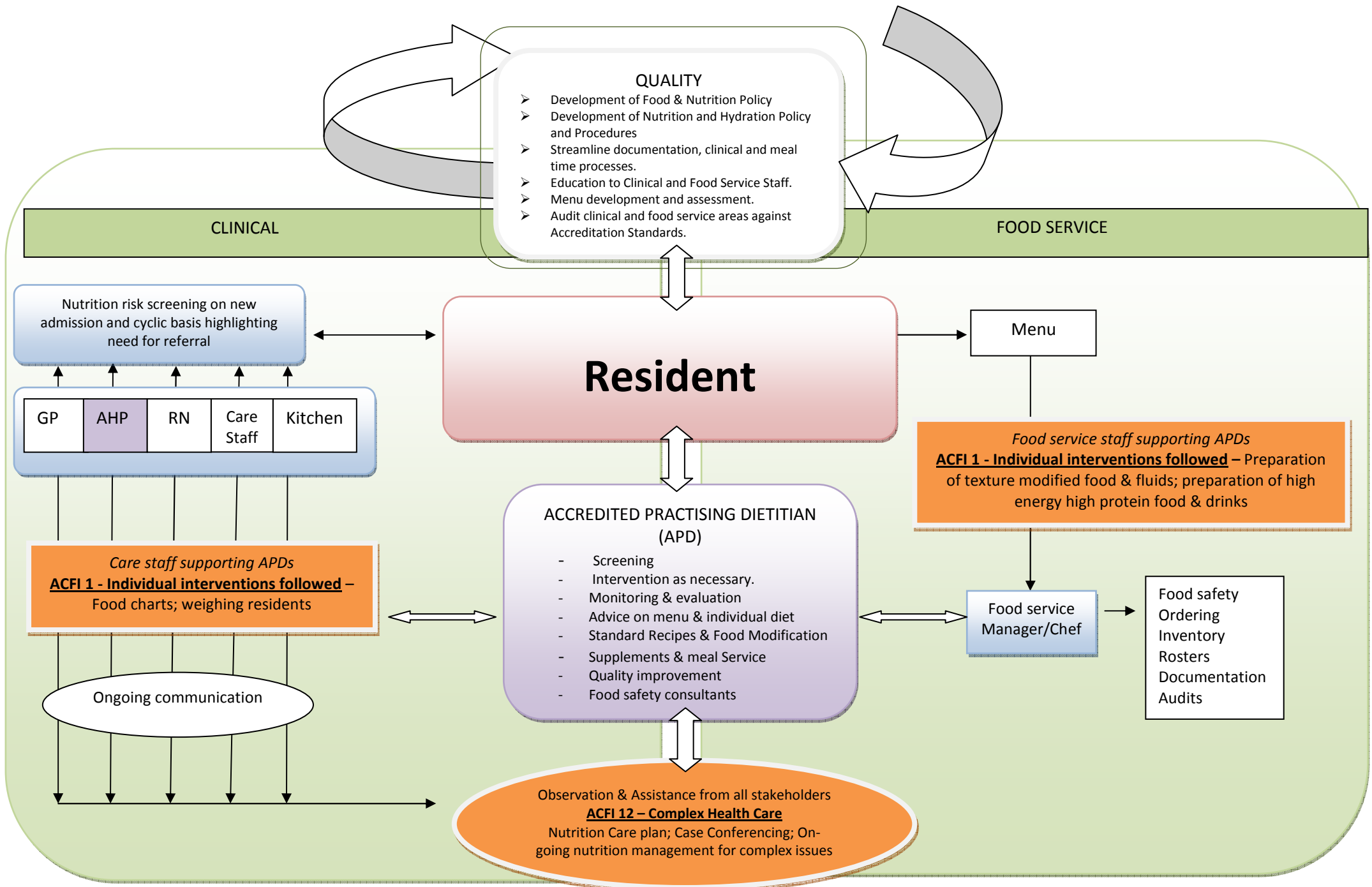
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APPENDIX I

See 'Role of Dietitian in Aged Care Facility' flowchart on the following page.

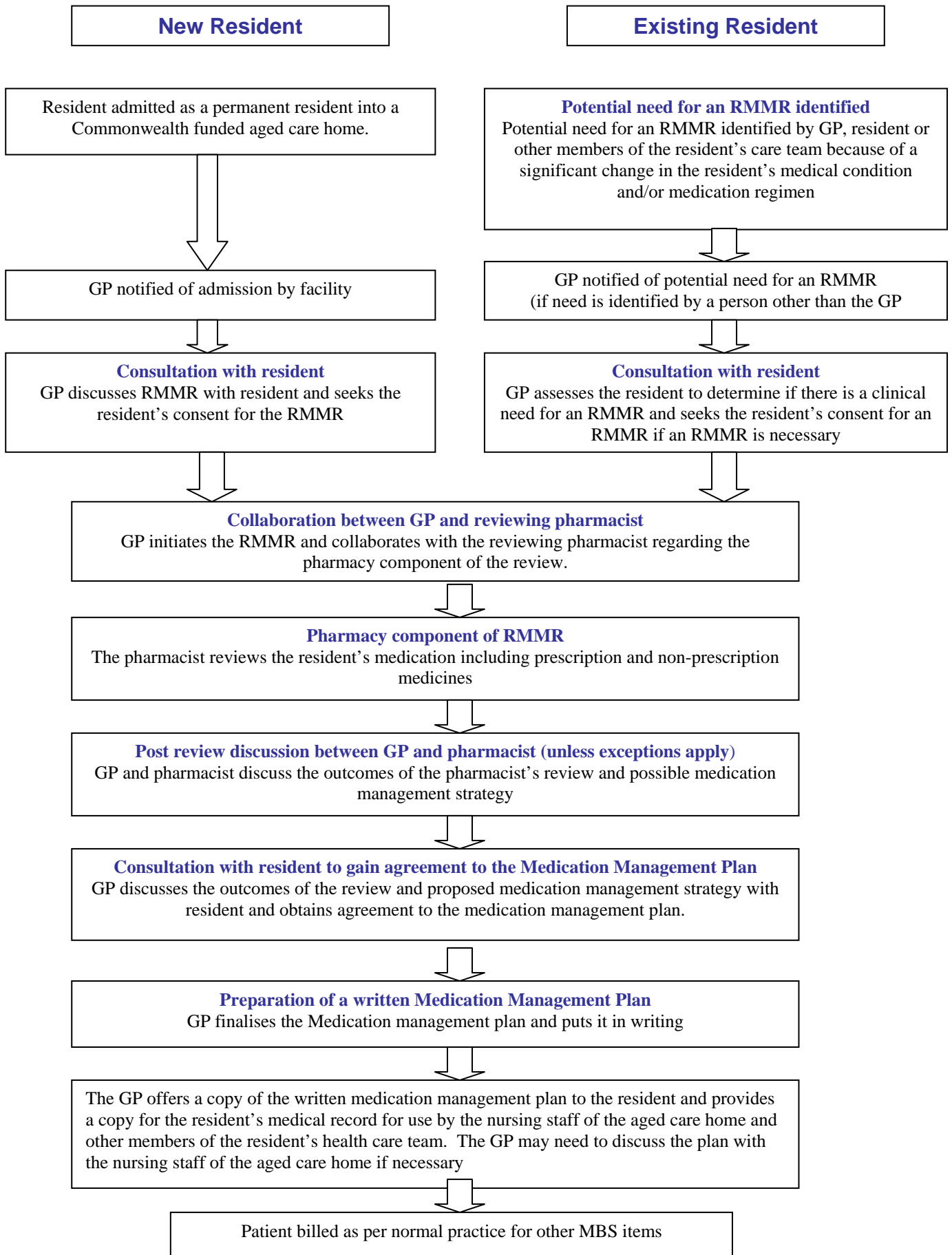
Role of Dietitian in Aged Care Facility: Highlighting proposed changes for ACFI



APPENDIX II

See the 'Residential Medication Management Review Service Description Flowchart' on the next page showing the current Pharmacist model.

RESIDENTIAL MEDICATION MANAGEMENT REVIEW SERVICE DESCRIPTION FLOWCHART



APPENDIX III

Residential Nutrition Management Review

Aim:

The proposed Residential Nutrition Management Review (RNMR) item, is to be payable where an Accredited Practising Dietitian (APD) provides nutritional screening using a recognised, validated screening tool. RNMRs would be available to all permanent residents of a facility in which residential aged care services are provided, as defined in the *Aged Care Act 1997*

Rationale:

Regular nutritional screening within residential aged care facilities will benefit residents by determining their nutritional status and flagging the need for therapeutic diet interventions to improve their health status and quality of life. Early detection and treatment of malnutrition and those at high risk of malnutrition has benefits to stakeholders.

Many residents enter Residential Aged Care Facilities (RACF) with one or more chronic disease states that are often directly impacted by the nutrition that they do or do not receive. Polypharmacy prescribed to counter these disease states often impacts residents' appetite, due to a variety of reasons, therefore making it essential that adjunct nutrition strategies are aligned with residents' overall health goals.

Current Models:

Residential Medication Management Reviews (RMMR) are currently funded by the Commonwealth, separate to other Aged Care health funding. RMMRs are conducted for residents that reside in Residential Aged Care facilities (RACFs), as defined under the *Aged Care Act 1997*. RMMR can be conducted collaboratively, initiated by the residents GP or initiated by the Pharmacist themselves, if they have a contracted provider agreement with the facility. RMMRs are not available for patients in a hospital, day hospital facility, those receiving respite care or people living in the community. Another model exists for funding those that are living in the community (Home Medication Reviews – HMR).

Proposed Model:

It is proposed that a RNMR could follow the same model as the RMMR, either being initiated by GPs or by the APD themselves. A baseline for the residents' nutritional health is established during their stay ideally upon admission to the RACF. The APD would initiate service provider agreements with RACFs.

Once the RNMR agreement has been completed by the APD, the residents are systematically assessed by the RACF upon admission, or soon thereafter. The RNMR would form part of regular admission processes. This alleviates the need for a GP to create a referral to an APD initially., It follows that should any further nutrition intervention be required, the GP can initiate the appropriate EPC in a timely and appropriate fashion.

This information is important and could contribute to a residents Comprehensive Medical Assessment (CMA), Enhanced Primary Care (EPC), ACFI and other care management strategies.

This system enables equitable access for RACF residents, one of our most vulnerable populations, to utilise the services of an APD. The service will be used to address the issue of malnutrition in aged care settings and to proactively manage appropriate nutrition interventions and contribute to improved quality of life for our frail and elderly.

Future Directions:

It is proposed to expand this service to include domiciliary RNMR for the aged living at home as a second phase and natural progression, to this initial project.

APPENDIX IV

About Accredited Practising Dietitians

Accredited Practising Dietitians (APDs) are qualified to advise individuals and groups on nutrition related matters. They also have clinical training to modify diets to treat conditions such as diabetes, heart disease, cancers, gastro-intestinal diseases, food allergies and intolerances and overweight and obesity.

APDs have sound university qualifications accredited by DAA, undertake ongoing training and education and comply with the Associations guidelines for best practice. They are committed to the DAA *Code of Professional Conduct* and *Statement of Ethical Practice*, and to providing quality service.

APD is the only national credential recognised by the Australian Government, Medicare, the Department of Veterans Affairs and most private health funds as the quality standard for nutrition and dietetics services in Australia. It is a recognised trademark protected by law.

DAA provides access to a register of current APDs and a search tool for health professionals and consumers to find a consulting APD online, see www.daa.asn.au

What is DAA doing in the aged care sector?

In 2010, DAA is planning to coordinate the development of Australian menu planning standards for the residential aged care setting.

DAA plans to engage with the Department of Health and Ageing on the review of Aged Care Accreditation Standards in 2010.

A number of Accredited Practising Dietitians who work in aged care and have a special interest in aged care nutrition have provided input into this submission.

APPENDIX V

Experience overseas

Canada

In Canada, there is tight regulation in Long Term Care (LTC). The LTC facilities are bound by the Community Care Facility Act which was developed by government to promote health and safety as well as quality of life for persons residing in LTC. Regional Licensing/Community Nutritionist and Licensing Officers inspect and monitor LTC facilities. In British Columbia, LTC facilities use a standard manual of audits and nutrition paperwork.

Dietitians of Canada and the LTC Action Group (a group within Dietitians of Canada) have lobbied for improved regulations. At present there is a minimum of 15min/month/resident of Registered Dietitian time which has been lobbied for 30min/month/resident (expected to be passed in June/July 2010). Legislation guidelines are detailed to include: Weight changes (e.g. significant weight changes, unplanned weight changes etc.), Dietary Services Provided (e.g. Food production, dining service, menu planning, supplies and equipment), Menus and food choices (e.g. specific minimum duration of menu cycles, therapeutic diets, choices in snacks and dietitian involvement), Food production (e.g. provision for perishable and non-perishable foods, standardized recipes, menu substitutions, recording, storage capacities in the kitchens, preparation of foods, food budgeting, sufficient staffing), Dining Service (e.g. posting of weekly menu, monitoring of residents during meal times, eating aides, time allowance, dining room furnishings, number of staff feeding residents at any given time), Dietitian (nutritional assessments, minimum time for each resident assessment per month, minimum time for dietitian clinical assessments based on FTE and resident ratios), Nutrition Manager (working in the capacity of food service and or clinical dependant on qualifications based on FTE and resident ratios), Cooks and food service workers, and Training and Qualifications.

UK

Malnutrition is also under-recognised and under-treated in the UK, to the detriment of and cost to individuals, the health and social care services, and society as a whole. Public expenditure on disease-related malnutrition in the UK in 2007 has been estimated at in excess of £13 billion per annum, about 80% of which was in England.

A report by the British Association for Parenteral and Enteral Nutrition recommends:

- Establishing a long term national strategy to tackle malnutrition – including development of a comprehensive nutrition strategy; better coordinated cross government action; a cross sector body should regularly report to Parliament; and an awareness raising campaign to the general population;
- Establishing accurate and reliable information on malnutrition through data collection and auditing.
- Removing barriers to screening –provision of adequate and appropriate equipment to public health services to measure height and weight; promote use of the same screening tool across settings for the same patient

- Educating the workforce – nutrition related training should be included in health, housing and social care professionals’ under and post graduate training and continuing professional development requirements.
- That government at all levels prioritise malnutrition
- An obligation of health care services, including aged care facilities to undertake nutrition screening and participate in national audits on the same.

Source: Elia, M. and Russell, C.A. 2009. Combating Malnutrition: Recommendations for Action. Output of a meeting of the Advisory Group on Malnutrition. British Association for Parenteral and Enteral Nutrition.

Europe

The recently published European report strongly recommends aged care providers to work with dietitians in a variety of ways to tackle the prevention and treatment of malnutrition. It also makes the following recommendations regarding screening:

- All residents screened on admission and then monthly. Also at time of medicine prescription change and on discharge/transfer.
- All residents weighed weekly.

Source: Nutrition in care homes and home care report and recommendations: from recommendations to action. Committee of Experts on Nutrition, Food and Consumer Health (Partial agreement) (P-SC-NU) Council of Europe Publishing Strasbourg, 2009.