# ***ENSURING GOOD NUTRITION* POLICY EVALUATION**
# **EXTERNAL STAKEHOLDER CONSULTATION QUESTIONNAIRE**

**Date: 20 June 2008** **Interviewer________________________**

**Questionnaire completed with:**

***Name:*** ***Annette Byron***
***Position:*** ***Policy Dietitian, Dietitians Association of Australia***
***Telephone:*** ***02 – 6163 5216***
***Fax:*** ***02 - 6282 9888***
***Email:*** ***abyron@daa.asn.au***

**Organisation represented:**

θ Allied Health Professional Organisation ***NSW members of the Dietitians Association of Australia Nutrition and Disability Interest Group***

θ **Consent received from informant** ***Date of consent*** not applicable

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**1. Are you aware of the Department of Ageing Disability and Home Care's *Ensuring Good Nutrition* Policy for people with disabilities in supported accommodation?** X Yes θ No

**1.1. What do you understand to be the goal or purpose of the *Ensuring Good Nutrition* Policy?**

- To promote increased awareness of nutrition issues.
- To reduce the risk of deaths attributed to malnutrition.
- To improve nutrition outcomes of people with disabilities in supported accommodation.

**1.2. What is your understanding of how this goal is to be achieved?**

- Through implementation of the nutrition and swallowing checklist and associated procedures.

**2. How effective do you think the *Ensuring Good Nutrition* Policy (EGNP) has been in improving the nutrition and health of people with disabilities in NSW?**

- Practitioners who have worked in the area say that things have improved with the EGNP. However the implementation of the Policy has not been consistent across the State and across care settings, nor is the Policy implemented as intended in every case. People in group homes are less likely to be seen by dietitians than people in institutional care. There has been an excellent initiative in the Hunter Region for dietetic services to group homes but DAA understands that funding for this is for a limited time only and only for limited services such as menu reviews rather than individual client care.
- The Policy is not always used for referral, but it is effective when it is used, especially the nutrition swallowing checklist.
- In some cases people are referred too late and are presenting with malnutrition.

**3. What do you think are the strengths of the Policy?**

- The policy has increased awareness of the importance of good nutrition for people with disabilities, and the role of dietitians in ensuring appropriate nutrition care.

- Where implemented the Policy should help to identify individuals who are at nutritional risk and who should be referred to a dietitian for nutrition assessment and intervention i.e. people who are enterally fed, those who are difficult to assess in terms of their weight or height, or those with swallowing issues,.
- The Policy provides information for workers who would otherwise have little knowledge about nutrition issues for people with disabilities. Furthermore the Policy provides clear guidelines for action by workers.
- In some settings the Policy has supported the case for the purchase of appropriate equipment by facilities e.g. scales for difficult to weigh clients.

## 4. What do you think are the limitations of the Policy?

- There are insufficient resources, in particular dietitians, in many areas to support the implementation of the Policy.
- It appears that the increased need for dietetic services that was predictable from the introduction of this policy has relied predominantly on access to private practice/consultant dietitians rather than on a response from government-funded dietetic services but this has not been sufficient to meet the needs of people with disability.
- Where, as a result of the policy, speech pathologists assess swallowing problems and recommend texture modified diets and/or thickened fluids this can lead to a client having a food intake which is safe to swallow but nutritionally inadequate. Access to the services of a dietitian is therefore needed wherever a speech pathologist's recommendations affect the person's diet. This is a duty of care issue as well as a principle of good practice.
- Workers do not always have confidence in implementing the Policy. In some instances this reflects lack of training, and in others a fear of doing the wrong thing by referring.
- The Policy is not sufficiently clear in the issue of 'choice' with respect to food for clients i.e. this could be expanded to demonstrate that clients should be offered 'healthy food choices' appropriate to the duty of care, rather than just 'free choice' which may not be consistent with the client's nutritional needs. This is particularly relevant for people living with an intellectual disability.

## 5. How well do you think the Policy has been implemented across State?

- Implementation has varied across the State and across care settings.
- Information in the Nutrition Kit is not always visible or available.
- Implementation has been most successful when the managers have identified nutrition as a priority. Also, success has been evident when Food Safety plans have been concurrently implemented and audits ensure the Policy has been implemented.
- Staff do not always do not consider referral as part of their role. An example given was the staff in community day centres of one service provider (supporting clients with an intellectual disability) who do not refer for dietetic consultations. It is not clear whether the staff working in day program areas are aware of the EGNP, and whether they have been trained. This is of concern given the fact that many clients spend significant amounts of time in these settings.
- In some cases clients from community settings are only referred to the dietitian when in respite care, for example for review of enteral nutrition, thus stretching the services of institutions providing respite.
- Access to dietitians is still insufficient to provide an appropriate care at an individual level in different care settings, with clients in group homes least likely to get the access they need.
- Furthermore, the limited access to professional nutrition services by dietitians limits the opportunity for them to contribute to multidisciplinary care in clients with complex needs. It also puts pressure on others in multidisciplinary teams to operate outside their scope of practice. At times this results in clients being placed on restrictive diets leading to malnutrition as a result of insufficient oral or enteral nutrition support.

### 5.1 What aspects of the Policy do you think have been the most effectively implemented?

- In some care settings the nutrition and swallowing checklist is being done, however planning does not always follow, or is not always done well.
- Weight monitoring is done well in some care settings, although appropriate action may not always follow. For example, overweight clients may be recognised but no action taken.

### 5.2. What aspects of the Policy do you think have been the least effectively implemented?

- Follow through on planning is not always evident, for example staff may understand the need to refer, but not to check that the client has actually accessed the nutrition care they require especially where there are waiting lists to see the dietitian.
- Nutrition care plans documented by staff are not always implemented. For example, an overweight client may have an eating and drinking plan documented but the plan is not consulted or followed by staff. Even if the plan is appropriate, lack of regular review means that there is no improvement in nutritional status.
- In some settings, particularly in group homes, the use of the Policy and manual to construct nutritionally adequate eating and drinking plans consistent with the Australian Guide to Healthy Eating does not occur.

### 6. In your opinion, how well trained are residential care staff in the Nutrition Policy and its implementation?

- Training was provided when the Policy was first established, however since then there has been no formal training evident. This is a problem given the number of new staff and casual staff employed who come into the service with varying levels of knowledge of nutrition issues for people with disabilities. Many workers not only lack basic knowledge of nutrition, but also practical skills such as cooking skills which are relevant in community settings.
- In the case of one provider supporting clients with intellectual disabilities, no training about the EGPN is provided for workers in community day centres. The only reference made to the EGPN is during induction and this only acknowledges the existence of the Policy, rather than how to implement the Policy.
- The lack of training is more apparent in group homes or community settings, and this is likely to increase as clients move from institutional care to group homes with the result that workers are unable to prepare adequate eating and drinking plans for clients.
- It some instances the house or network managers are trained, but this does not filter down to health care workers.
- In some care settings there has been money for in-service training for nurses, but this has been of limited duration and training in nutrition appears to be of low priority relative to other issues in a climate of limited funding.

### 7. When nutritional problems are identified in people with disabilities, do you feel that appropriate actions are taken?

☐ Yes ☐ No θ Don’t know *Please give details*

- Clients in institutional care with greater access to dietitians are more likely to receive appropriate nutrition care when problems are identified, for example through annual health checks.

**8. When nutritional problems are identified in accommodation services, do you feel that appropriate referrals are made to health professionals?**

☐ Yes ☐ No θ Don't know *Please give details*

- Nutritional problems are less likely to be identified in community settings or group homes, and clients are less likely to receive appropriate nutrition care, including access to a dietitian.
- In some cases, other professionals act outside their scope of practice with respect to nutrition interventions and in some cases these place the client at risk. This is particularly the case where clients are place on restrictive meal plans because of swallowing issues but there is no referral to a dietitian to prepare an appropriate meal plan, and oral or enteral nutrition support is not investigated. Some professionals who feel compelled to act outside of their scope of practice report that they would be much more comfortable referring to a dietitian but feel that this is unrealistic as they do not have a to whom they can refer, or the waiting lists are unacceptably long in the community setting.

**9. Do you think that people with disabilities have a sufficiently wide variety of food choices of available in supported accommodation?**

☐ Yes ☐ No θ Don't know *Please give details*

- The food choices available vary according to the nutrition knowledge of workers, and their skills in food preparation, shopping, understanding of food labels.
- There appears to be a lack of consideration of nutrition issues in the tendering process with respect to tender specifications of food items.

**10. Do you think that people with disabilities and/or families have sufficient input into development of nutrition and meal plans in supported accommodation?**

☐ Yes ☐ No θ Don't know *Please give details*

This varies across care settings.

**11. Do you think that religious or cultural preferences are adequately taken into account in the provision of food for people with disabilities in supported accommodation?**

☐ Yes ☐ No θ Don't know *Please give details*

- Religious or cultural preferences appear to be taken into account in most care settings.

**12. Do you have any suggestions on how nutrition related illness and deaths of people with disabilities in supported accommodation can be reduced?**

- Increased access to dietitians to provide individual client support, to support others in multidisciplinary care teams, and to provide systemic support. Systemic support should strengthen food service systems, and nutrition care by health professionals and health workers in various care settings. This is particularly important for prevention and treatment of malnutrition, but also for chronic diseases such as obesity and diabetes.
- NGOs providing care in the community sector should be required to provide an appropriate level of nutrition care at an individual and systems level.
- The importance of early referral for nutrition problems should be highlighted, as referrals are still being received too late.
- Improved monitoring of people with disabilities receiving enteral nutrition to prevent treatment in Accident and Emergency Departments, or death in more serious cases.

- Increased training for staff at different levels in nutrition issues for people with disability.

### 13. Do you have any other comments on how the *Ensuring Good Nutrition* policy, its implementation or monitoring can be improved?

- The EGNP has provided an opportunity to improve the nutrition of people with disability in NSW. DADHC is to be commended on implementing and evaluating the policy yet there considerable room for improvement. This could be partly achieved by the senior management of service providers, and Boards of Directors, directing and encouraging staff to implement the EGPN.
- However, unless fundamental workforce issues are addressed the policy will ultimately have little impact. Better access to dietitians is needed to provide individual care to people with disabilities, to work in multidisciplinary teams and to support managers and workers to ensure a safe and adequate system to support the EGPN.
- This lack of access to services is not consistent across disciplines, and other allied health professionals employed by DADHC are put in the position of acting outside of their scope of practice. In areas where there has been project based funding the support for greater participation from other disciplines, such as Speech Pathology, has been considerable.
- DADHC has indicated to DAA members that it does not have a responsibility to add dietitians to their community support services because this is the responsibility of NSW Health. However, NSW Health does not concede that it is their responsibility either, nor are HACC dietetic services available to recipients of disability supported accommodation. This buckpassing between departments means that some of the most vulnerable people in the State are not having their basic human right of adequate nutrition met. DAA calls for the Department of Health and DADHC to urgently address this issue to improve access to dietitians in this sector.
- NSW Members of the DAA Disability Interest Group would welcome the opportunity to participate in discussions on how further improvements might be achieved in terms of implementing the EGPN in determining indicators to gauge the success of future efforts and in providing an appropriate dietetic workforce to people with disabilities in New South Wales, for example through the "Stronger Together" initiative.

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