



10 August 2010

**Submission from the Dietitians Association of Australia
to the Productivity Commission: Caring for Older Australians**

Context

The Dietitians Association of Australia (DAA) is pleased to provide a response to the Productivity Commission on their inquiry 'Caring for Older Australians'. The issues paper outlines the current Australian aged care system in all its complexity and raises many valid issues and questions. DAA agrees that the Australian aged population is growing and that this flows on to an increased demand for aged care health services. DAA is particularly interested in high quality nutrition services being accessible to older Australians and the implications of the increased demand on the required workforce to deliver such services.

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

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Key Recommendations

1. That older Australians have timely access to evidence based nutrition and dietetic services across all parts of the aged care system.
2. That Accredited Practising Dietitians (APDs) are considered part of the essential health professional workforce required across the aged care system to deliver evidence based nutrition and dietetic services.
3. That accreditation standards across the aged care system provide incentive for organisations such as hospitals and Residential Aged Care Facilities (RACFs), to undertake routine nutrition risk screening and deliver evidence based nutrition and dietetic services.
4. That organisation level and preventative nutrition services are adequately funded across the aged care system. Activities such as establishing routine nutrition risk screening systems; menu assessment; education and training of support staff/ community based care providers on fundamental nutrition principles, accurate client weighing; feeding skills; and health promotion.
5. That individualised medical nutrition therapy is adequately funded across the aged care system. For example, expansion of the Medicare Chronic Disease Management items and expansion of government funded, community based services.

6. That the Commonwealth monitor nutritional status across the aged care system and report on the prevalence of malnutrition.

1. Introduction

DAA is responding to two key questions from the issues paper:

- *Are the aged care services that older Australians require available and accessible? Are there gaps that result in a loss of continuity of care? How might inadequacies in the system be addressed?, page 13.*
- *Views are sought on reform options to secure a larger, appropriately trained and more flexible formal aged care workforce in to the future. In particular, views are sought on the need for and nature of reforms to models of care, scopes of practice, occupational mix, service delivery, remuneration, education, training, workforce planning and regulation, page 26.*

2. Current availability and accessibility to nutrition services for older Australians

Nutrition and dietetic services in the Australian aged care system

Dietitians provide aged care services in the field of nutrition and dietetics across Australia. However these services are not consistently available and easily accessible to older Australians in all states and territories. This inequity can result in service gaps and also confusion in the sector about the (potential) role of dietitians.

The role of dietitians in aged care

Accredited Practising Dietitians (APDs) are recognised professionals with the qualifications and skills to provide expert nutrition and dietary advice. APDs work at the individual and organisation level across the aged care system in Australia. (See Appendix 1)

Dietitians work with residential aged care facilities (RACFs), individuals living at home, acute and rehabilitation care in hospitals, community health centres, Aged Care and Assessment Teams, in private practice and through HACC (Home and Community Care) programs in NSW, VIC, QLD and TAS.

Services provided by dietitians in the aged care system across Australia may encompass the following nutrition and dietetic activities:

Organisation level

- Development of organisation food and nutrition policy
- Development of streamlined systems/models of care e.g. weight monitoring, nutrition risk screening, nutrition referral pathways, dietary intake reporting.
- Education of nursing and food service staff, volunteers and carers on nutrition issues such as nutrition risk screening, recipe formulation (e.g. high energy, modified texture), height and weight measuring techniques, dietary intake monitoring, appropriate nutrition supplement use.
- Work with RACFs to meet Commonwealth accreditation requirements related to nutrition and food service
- RACF/community organisation/hospital menu assessment, evaluation and advice to ensure menu meet appropriate nutritional recommendations.
- Quality improvement projects, e.g. evaluation of nutrition screening and interventions; plate wastage surveys; food satisfaction surveys.

- Health Promotion, e.g. advise organisations on activities to promote nutritional health and wellbeing.
- Help organisations to establish a meal time environment that promotes good nutrition and adequate fluid consumption.

Individual level

- Individualised dietetic interventions, such as medical nutrition therapy.
- Participation in multidisciplinary team care meetings with GPs, nurses, care staff and other allied health professionals to discuss and develop plans for individuals.
- Regular review of individuals with nasogastric or percutaneous endoscopic gastrostomy feeding regimens.
- Monitoring of individuals' weight status over time.
- Assist individuals in the community and RACFs to order appropriate nutritional supplements, including liaison with Department of Veteran Affairs and supplement suppliers.

3. Gaps in nutrition services for older Australians

Nutrition status largely determines quality of life, independence and overall health of older adults². Access to food is a fundamental human right³. Malnutrition and chronic disease are the major issues linked to nutritional health seen in the Australian older population. Despite the importance of nutrition, there is no current food and nutrition policy for Australians, let alone for older Australians.

Consequently there is no coordinated approach to addressing the issues of older Australians which may include the following:

- Malnutrition/unintentional weight loss/ under-nutrition
- Pressure ulcers / Chronic wound management
- Dysphagia (ensuring nutritional adequacy of texture modified diets)
- Overweight/ obesity (This is often an issue for care staff/home carers when washing, dressing; also implications for RACFs re: equipment such as toilet seats, dining room chairs, beds, walkers etc)
- Hydration
- Type 1 and 2 Diabetes
- Kidney disease
- Coeliac disease, food allergies and lactose intolerance
- Bowel function irregularity, e.g. chronic constipation
- Feeding regimens for enteral feeding tubes
- Parkinsons disease and motor neurone diseases

Malnutrition

Malnutrition is recognised by DAA as the major nutritional concern amongst older Australians. Malnutrition is commonly defined^{4,5} 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.

Malnutrition is associated with adverse clinical outcomes and costs⁴. Malnutrition is commonly under-recognised and under-diagnosed and therefore untreated⁴. The prevalence

of malnutrition tends to increase with age and is a widespread issue in Australian older adults⁶ across various settings:

- around 40-70% in Australian residential aged care setting^{4,5,6}
- around 10-30% in the community setting⁴,
- around 20-50% in the acute setting⁴,
- and around 30-50% in the rehabilitation setting⁴.

Evidence^{3,7,8,9,10} 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 the health system. Therefore there are significant cost implications of malnutrition. Malnourished individuals and the consequent decline in general health can often be prevented through evidence based dietetic intervention^{10,11,12,13}.

Chronic Disease

Chronic disease is prevalent in older Australians. The most prominent health conditions for older Australians in terms of death and hospitalisation are heart disease, stroke and cancer¹⁴. Dietitians have a role to play in the health care team in chronic disease management and this has been recognised by the current Medicare chronic disease management program¹⁵. This program allows Australians limited access to Accredited Practising Dietitians and other allied health professionals to treat chronic conditions such as diabetes and heart disease. Delayed early intervention for older Australians with chronic disease/s leads to increased morbidity, decreased quality of life and increased health care costs. It is important then for the aged care system to support funding models that include mechanisms to achieve early detection and intervention.

Gaps in Residential aged care nutrition services

- Currently there is inconsistent access to APDs amongst RACFs. RACFs require resourcing/incentives to access APDs to implement nutrition risk screening systems and to treat individuals identified as being at risk.
- Improved aged care Accreditation standards could provide an appropriate incentive to ensure nutrition quality indicators are monitored and acted on. For example, DAA would like to see nutrition risk screening incorporated into Accreditation Standards; unintentional weight loss recorded as an essential quality indicator and an incentive to ensure that facility staff are trained in appropriate feeding techniques and accurate weight measurements.
- The development of national menu planning standards for the residential aged care setting is needed. Agreed standards would help aged care providers deliver nationally consistent, appropriate diets to residents and ensure equity for aged care residents in Australia.

Gaps in HACC programs/ Community services

- There is no consistent policy about how nutrition services under HACC programs are to be delivered. Some have resourcing to provide direct clinical dietetic services, others are resourced to deliver nutrition education and training of community based carers. DAA would like to see HACC programs resourced to deliver both

individualised direct clinical services as well as training and health promotion activities.

- There is a gap in standards of care for this setting. Nationally consistent standards would be welcomed.
- The Malnutrition guidelines⁴ provide evidence and suitable validated tools for screening in the community setting however some HACC programs are not funded to implement such systems.
- DAA would like to see HACC programs support dietitians to undertake proactive work with community agencies to identify and treat members of the community at nutritional risk.

Gaps in Medicare

- The current chronic disease Medicare items are inadequate. Australians with a chronic disease can access five visits to allied health practitioners per year. These limited item numbers are currently shared across allied health professionals. People with a chronic disease often require multiple visits with a number of allied health service providers to achieve improved health outcomes and better management of their chronic condition/s. DAA calls for expansion of this program.
- DAA understands that the current MBS is commencing a review including the development of a quality framework and will be contributing to this process.

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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

About DAA

The Dietitians Association of Australia (DAA) is the national association of the dietetic profession with over 4300 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.

Current DAA activities in aged care

DAA supports members working in aged care to network through professional development events and a national interest group, the 'Rehabilitation and Aged Care Interest Group' who connect via a list serve.

DAA is currently planning a project 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 upcoming review of Aged Care Accreditation Standards to ensure that nutrition is better addressed un the revised version.