Aged Care Program Redesign: Services for the Future

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The Dietitians Association of Australia is the national association of the dietetic profession with over 7,500 members, and branches in each state and territory. DAA is a leader in nutrition and advocates for food and nutrition for healthier people and healthier communities. DAA appreciates the opportunity to provide feedback to the Royal Commission into Aged Care Quality and Safety regarding the redesign of aged care services for our nation's future.

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DAA interest in this consultation

As the leading organisation of nutrition and dietetic professionals in Australia, the Dietitians Association of Australia (DAA) supports reforms to aged care systems and services to better support older Australians who have reduced capacity to care for themselves. In particular, DAA considers it vital that the aged care system is changed to improve the availability of allied health services, including dietetic services and nutrition supports.

The Accredited Practising Dietitian (APD) program provides an assurance of safety and quality and is the foundation of self-regulation of the dietetic profession in Australia. Accredited Practising Dietitians have an important role to play in aged care, such as in the assessment and dietary management of clients with chronic diseases and malnutrition, in the planning and coordination of food service within aged care homes and home delivered meal programs, and in the training of aged care sector staff.

Response to the Design Questions

1. **What are your views on the principles for a new system, set out on page 4 of this paper?**

   DAA agrees with the principles for a new system as proposed in the consultation paper on Aged Care Program Redesign (Consultation Paper 1).

2. **How could we ensure that any redesign of the aged care system makes it simpler for older people to find and receive the care and supports that they need?**

   It is vital that any redesign of the aged care system captures the issues and recommendations by way of inclusive consultation with all relevant stakeholders, including allied health professionals, with experience and responsibilities in aged care.

   Inadequate consultation with the peak bodies of allied health professions in the past has resulted in major failures with access to allied health services, including dietetic services and nutrition supports in both the community and residential aged care. Allied health professionals are responsible for referring older people in their care from hospitals or health services to their counterparts in other care settings. They also receive older people referred from health services or other points of referral and yet their insights have not been captured sufficiently in previous consultations. DAA welcomes consultation on the redesign to help

identify the gaps and solutions in improving older peoples' access to dietetic services and nutrition support products within the aged care system.

3. **Information, assessment and system navigation. What is the best model for delivery of the services at the entry point to the aged care system—considering the importance of the first contact that older people have with the system? This includes looking at services provided by phone and website as well as face-to-face services.**

   DAA agrees face-to-face support is a vital component of entry point to the aged care system. With regards to the issue about system navigators, no matter who provides the face-to-face support, the staff involved need to be adequately trained and work together with a team of professionals, including a team of allied health professionals, to adequately assess the needs of older people needing assistance and services within the aged care system. While My Aged Care contact centre staff, the My Aged Care Regional Assessment Service (RAS) and Aged Care Assessment Teams (ACATs) have access to the National Screening and Assessment Form (NSAF), training of the tool is apparently lacking. More concerning is the fact that these teams do not currently have access to a team of allied health professionals, so they are unable to make comprehensive and appropriate assessments of the needs for allied health services, including dietetic services and nutrition supports.

   Screening for food and nutrition problems should be an inherent part of the entry point assessment for access to minimal or comprehensive services given the high rates of malnutrition and chronic disease among older Australians. The impact of minor changes in functional abilities of an older person can have an insidious and cumulative effect on their nutritional status. Malnutrition increases the risk of falls, osteoporosis and fractures, slow wound healing, morbidity, mortality and contributes to poor quality of life. Malnutrition is an accelerator to entry to residential aged care.

4. **Entry-level support stream. People maintain their homes and gardens, do laundry, cook meals, get themselves to appointments and attend social engagements across their whole adult lives—some people may choose to pay others to do these things—but mostly they handle them with little assistance. As people age and need support with everyday living activities, how should Government support people to meet these domestic and social needs?**

   With regards to the entry level support stream and assistance with meals, DAA considers it important that the assessment is sufficiently thorough to ensure assistance with meal meets the needs of the older person. The assessment needs

to adequately identify help required with shopping, cooking, safe food handling and eating. It also needs to identify the need for allied health care services, including dietetic services for assistance with dietary issues.

Assistance with meals is not a low level support, given the implications it has for health and wellbeing. As already highlighted, malnutrition is a risk factor for frailty and other poor health outcomes and it is an accelerator to entry to residential aged care. Therefore the staff who provide assistance with meals to older people in their own homes and communities need basic nutrition training, with the support of an Accredited Practising Dietitian (APD) to facilitate the training on nutrition essentials, shopping, cooking and safe food handling. DAA proposes increased funding for 'meal assistance' to allow for initial and ongoing staff training, supported by an APD.

In some cases, home delivered meals are provided but these provide one third of a person's estimated dietary requirements. Unless additional measures are taken following assessment by an APD, it is likely that the nutritional status of the person will decline.

5. **Investment stream. The benefits from regular and planned respite, reablement and restorative care are well documented, but the services are in short supply. What incentives, including additional funding, could be introduced to encourage providers to offer greater and more flexible options, including major home modifications and assistive technologies, which meet the needs of the older person, carer and caring relationship?**

It is imperative that dietetic services, nutrition supports and nutrition training (delivered by APDs) are imbedded in restorative aged care programs that aim to improve older people's functional ability and independence. The World Health Organization (WHO) recognises malnutrition as one of six contributing factors to the declining physical and mental capacity of older people[1]. A study published in 2012 identified that the prevalence of malnutrition in older Victorians receiving home nursing services was around 8% and approximately 35% were at risk of malnutrition[2]. It is therefore vital that nutrition care, with the support of Accredited Practising Dietitians, is integral to restorative aged care to prevent and manage malnutrition and help older people stay in their home or transition from hospital back to their home.

DAA proposes that access to services in the community be mapped in the first instance to identify areas which do not have the necessary range of services, including allied health professionals.

DAA also calls for increased funding for food and nutrition support systems to help identify elderly people at risk of malnutrition and chronic disease in the community. The funding must support professional dietetic services and nutrition care products as part of the restorative care of elderly Australians.

References:

1. World Health Organization (WHO) Guidelines, 2017. Integrated Care for Older People - Guidelines on community-level interventions to manage declines in intrinsic capacity. Available from: https://www.who.int/ageing/publications/guidelines-icope/en/

2. Rist G, Miles G, Karimi L. The presence of malnutrition in community-living older adults receiving home nursing services. Nutr Diet 2012; 69:46-50.

6. **Care stream. As people's needs increase and go beyond what can be managed with entry-level support or with their carer, they may need care services—personal care, as well as nursing and allied health. What are the advantages and disadvantages of developing a care stream, independent of setting?**

DAA considers it imperative that care streams, regardless of setting, include adequate funding and resourcing for allied health services, including dietetic services (e.g. nutritional status screening and assessment; personalised dietary advice and care plans; best practice food service support; staff training on nutrition essentials etc). Dietetic services should be made available across the entire support and care continuum to those who need them (even for people receiving entry level supports).

The introduction of My Aged Care largely replaced block funding with individual funding. While this may be appropriate in terms of choice and control for the consumer, it also carries disadvantages.

The value of block funding is that it can be used for system wide changes and training of staff such that the needs of all people receiving services are recognised and addressed. For example, a program to train staff to screen for food and nutrition problems at entry to care can identify problems early so that low level interventions can occur before the older person loses condition and function. Block funding would enable an Accredited Practising Dietitian to work with a home delivered meal service to ensure that the meals prepared meet the nutritional requirements of older people receiving meals. In residential care, block funding would enable Accredited Practising Dietitians to support menu development, work with food service staff and carers to audit processes across

the production and delivery of meals, and to measure plate waste to guarantee the quality of meals and support provided to residents really meets their needs. Having an Accredited Practising Dietitian review a resident in isolation from the food and nutrition system may not be effective if the food and nutrition system around the resident is not robust.

7. **Specialist and in reach services. How could the aged care and health systems work together to deliver care which better meets the complex health needs of older people, including dementia care as well as palliative and end of life care? What are the best models for these forms of care?**

Dementia care teams do not routinely include Accredited Practising Dietitians, yet approximately 50% of all people have lost bodyweight in the year prior to diagnosis. This weight loss is indicative of loss of lean body mass and malnutrition. Any loss of lean body (muscle) mass in an older person potentially increases morbidity and mortality. Weight loss in someone living with dementia rapidly impacts quality of life as well as physical and cognitive capacity. DAA therefore considers it vital to include APDs in dementia care teams to support older people with dementia and to guide other workers in nutrition care. An understanding of nutrition risks associated with dementia can identify modifiable issues around eating to assist individuals to continue enjoyment of food and drinks and maintain adequate nutritional intake.

The observation of DAA members is that more needs to be done in all care settings to ensure nutrition screening and assessment is in place, and that processes are in place to ameliorate the impact of dementia on nutrition.

Nutrition is also an important part of advance care planning, especially when texture modified meals, thickened fluids and enteral feeds are required. Not eating is part of the process of dying so it is normal for people to eat little or no food at that time, and while associated weight loss is common, it may not occur until the final days in some people.

The food service systems supporting residents in the community, aged care facilities need to be flexible and varied to meet the needs of those person's approaching the end of their lives. Food and support around food and nutrition should add "quality" to their lives, but in many cases it doesn't.

People should have an eating and hydration plan that supports dignity and quality of life, keeping them as comfortable as possible while addressing requests. Family members and carers should be reassured that all appropriate measures are being

offered for the enjoyment of food, as appropriate and as desired by the individual. Given the important role that APDs play in palliative and end of life care, DAA recommends imbedding APDs in palliative and end of life care teams to:

- help plan and document the nutrition care for each person in advance care plans, as per the Nutrition and Hydration Guidelines for Hospitals and the National Safety and Quality Health Service (NSQHS) Standards.
- accommodate food/meal preferences and choices for people at the end of life in consultation with individuals and their families.

8. **Designing for diversity. Caring for people with diverse needs and in all parts of Australia has to be core business—not an afterthought. How should the design of the future aged care system take into account the needs of diverse groups and in regional and remote locations?**

Elderly Australians who reside in rural and remote locations are certainly disadvantaged when it comes to accessing allied health services. Access to allied health services through Medicare Allied Health Chronic Disease Management items is limited to five services per year across all eligible professions, where each session is a minimum of 20 minutes. This is rarely sufficient to meet the complex needs of older people. In addition to this, allied health professionals are not entitled to telehealth services, which significantly reduces access to allied health supports for people living in rural and remote locations.

In light of this, DAA proposes to:

- Increase the number of services and duration of service available under Medicare Allied Health Chronic Disease Management items to improve access to Accredited Practising Dietitians working in the private sector for the management of malnutrition and enteral feeding in the community.
- Include allied health professionals in the delivery of care via telehealth services.

Other considerations identified by DAA – training of the aged care workforce

Improvements in all care settings requires a 'nutrition is everyone's business' approach to the development and implementation of policies and procedures related to nutrition care, food services and hydration, including identifying any risks and implementing interventions to mitigate and manage those risks. Programs must include a system to monitor nutrition care and take action when

necessary. Accredited Practising Dietitians have a key role in leading the workforce to improve outcomes for older people.

DAA considers that the redesign of aged care systems must address capacity building for the aged care workforce, which is currently problematic. Here follows several recommendations to address workforce training issues specific to nutrition care in the aged care sector. DAA recommends to:

- Include food and nutrition training (including malnutrition screening) as a core component of entry level training for all care staff and support workers working in residential and community aged care (including Commonwealth Home Support Programme staff, Home Care Package providers, My Aged Care staff, Regional Assessment Staff).
- Ensure funding models support in-house nutrition training for all care staff and support workers working in residential aged care, day programs, respite care and community care to keep skills current in malnutrition screening, referral pathways and documentation processes. Funding should support maintenance of services at acceptable levels to older people while workers are off the floor for training.
- Build competency of staff by reviewing the content of vocational education training qualifications and units for care workers, chefs and kitchen staff to ensure the material developed and delivered is evidence-based and addresses management of food and nutrition related risks experienced by older people (i.e. malnutrition, dysphagia, food allergy and intolerance, therapeutic diets, and food safety).
- Promote better nutrition outcomes for older people, other health professionals, and support workers by including Accredited Practising Dietitians in community education programs directed at reducing the risk of falls, wound management etc.
- Change Medicare and DVA health care arrangements to allow allied health students on placement to deliver part of the service when supervised by a qualified allied health care professional. The current system is a major barrier to supporting students in exposure to practice in aged care, and to gaining skills and knowledge in aged care to prepare them for practice after graduation.