Commonwealth Home Support Programme

Programme Manual

April 2015

The Dietitians Association of Australia (DAA) is the national association of the dietetic profession with over 5800 members, and branches in each state and territory. DAA is a leader in nutrition and advocates for better food, better health, and wellbeing for all. DAA appreciates the opportunity to provide feedback on the Commonwealth Home Support Programme – Programme Manual by the Australian Government Department of Social Services.

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Key messages

Accredited Practising Dietitians are the dietetic and nutrition professionals with the skills and knowledge to support older Australians regarding nutrition, and to work with consumers, carers, the CHSP workforce and providers to achieve better wellbeing and reablement in the community.

National Nutrition Guidelines are needed to ensure nutritious meals are produced and delivered by paid staff and volunteers in meal services, or in other food services under the CHSP.

Discussion

DAA is supportive of consumer directed care. The Commonwealth Home Support Programme has the potential to address the unacceptably high right of malnutrition in older Australians living in the community. DAA would like to see more emphasis on measures to address this in the CHSP Programme Manual and makes the following specific comments.

Page	Comment
12	Regarding Service Types, Accredited Practising Dietitian (or at least dietitian) should replace 'nutritional advice from a qualified dietitian or nutritionist'. Medicare, DVA, Private Health funds and employers recognise Accredited Practising Dietitians as the professional group qualified to provide nutrition and dietetic services. The Department of Social Services recently amended the MyAgedCare website to reflect the role of dietitians. The CHSP Programme Manual should be similarly amended by adding dietitian to the list of Allied Health and Therapy Services. Nutritionists are not qualified nor recognised for the purpose of nutrition and dietetic services and should not be listed in the CHSP Programme Manual.
20	Regarding Service type description, 'Nutritious' should be added to describe meals prepared and delivered to the client's home and provided at a Centre or other setting. DAA supports the recommendation of the Meals Review that National Nutrition Guidelines be developed for CHSP meal services. Clients receiving meals are vulnerable who rely on meals as a key source of the nutritional intake. DAA considers that service providers have a duty of care to provide meals with meet minimum nutrition requirements.
20	Regarding Use of funds, DAA is concerned about the increased cost of ingredients for clients living in remote regions, and the increased cost of culturally specific and special diet type meals. Clients may not have choice of provider in these circumstances and may choose not to purchase such meals with adverse consequences on their nutritional status. DAA would like to see specific measures for remote clients and those with special needs to ensure that they are able to access the services needed for wellbeing.

20	Regarding Legislation, Grant recipients must comply with relevant legislation and regulation with respect to safe food handling practices. They should also be required to meet nutrition quality guidelines. DAA would welcome the opportunity to work with the Department of Social Services on the development of National Nutrition Guidelines for CHSP meal services.
20	Regarding Staff Qualifications, DAA agrees that paid staff and volunteers must be qualified with respect to safe food handling practices. DAA considers it is also essential that they have the necessary skills and knowledge to meet the nutrition needs of the target population, including how to prepare meals for older people, culturally appropriate meals and special diet types for individuals or groups of people.
21	Regarding Service type description, Accredited Practising Dietitians are the recognised professional group to provide nutrition advice to clients. A Certificate IV Nutrition and Dietetics Assistant under the guidance of an Accredited Practising Dietitian would also be appropriate. Other assistance with preparing and cooking a meal in a client's home might be undertaken under the direction of an Accredited Practising Dietitian by another person with training in how to prepare meals for older people, culturally appropriate meals and special diet types.
31	Regarding Service type description, as per earlier comment, Accredited Practising Dietitians are recognised as the professional group qualified to provide nutrition and dietetic services. The Department of Social Services recently amended the MyAgedCare website to reflect the role of dietitians. The CHSP Programme Manual should be similarly amended by adding dietitian to the list of Allied Health and Therapy Services. Clients of the CHSP are the face of the 8% of older Australians in the community who are malnourished, and the 35% who are at risk of malnutrition. Dietitians are recognised for their contribution to multidisciplinary care in other settings, e.g. rehabilitation[4]. It is not acceptable to say that the list of service types is not exclusive. Omitting key professional groups such as dietitians sends a message that the service is either not important or is not available.
33	Regarding Service type description, Goods, equipment and assistive technologies related to home enteral nutrition should be included in the categories listed. Not all clients who require short or long term enteral nutrition will be on packages at home, and in some cases should be supported under CHSP arrangements while living independently at home.
41	The client scenario describes someone who 'is avoiding the shared kitchen' and 'has lost weight'. The scenario should be amended to show referral to a dietitian as a consequence of answering 'yes' to the screening question of 'have you lost weight recently without trying'. The dietitian would undertake a holistic assessment and work with the client to plan to address all of the contributing factors to his poor nutritional status. DAA would be pleased to assist the Department of Social Services with refinement of this scenario. DAA agrees with the client centred approach of the CHSP, and that client

	goals, choice and flexibility are important. The experience of DAA members with the elderly, especially those who are malnourished, is that they see weight loss as part of getting old. They consider poor appetite as normal and consistent with lower activity levels. It is also the experience of members with current care models that clients sometimes other services over meal services or supplements where there is a funding limit on services for example medication, home modifications and equipment aids, incontinence aids etc. *"It has been our experience to date that despite receiving funding for packaged care these funds are exhausted by basic care needs and are insufficient to pay for private services".* DAA considers that RAS assessors will need to be alert to these perceptions and ensure that comprehensive screening is undertaken using the NSAF in order to set up appropriate plans to identify malnutrition or risk of malnutrition in the context of improved wellbeing and reablement. It is the experience of DAA members that better nutrition care results in better outcomes for clients. (See appendix for case studies). There is evidence also that clients with better nutritional intake respond better to other allied health interventions for reablement. A pilot study by the East Maitland Community Health Centre demonstrated improved body weight, grip strength and energy intake over 12 weeks. The dietitian led evidence based program for clients with unintentional weight loss actively involved clients in goal setting and program design. (See appendix for details).

References

1. Rist G, Miles G, Karimi L. The presence of malnutrition in community-living older adults receiving home nursing services. Nutrition & Dietetics 2012; 69: 46-50
2. Charlton, K. Time to address the skeletons in the hospital – and bedroom – closet. Australian Association of Gerontology Newsletter 2014; September
3. Luscombe-Marsh N, Chapman I, Visvanathan R. Hospital admissions in poorly nourished, compared with well-nourished, older South Australians receiving 'Meals on Wheels': Findings from a pilot study. Australasian Journal on Ageing 2013 doi:10.1111/ajag.12009
4. Standards for the provision of inpatient adult rehabilitation medicine services in public and private hospitals 2011. Australasian Faculty of Rehabilitation Medicine and the Royal Australasian College of Physicians.

Appendices

Case Study 1

50 yr old female referred to HACC dietitian with severe malnutrition and physical decline following 2 month hospital admission due to pneumonia on background of COPD and spina bifida.

Initial assessment

- living alone, dependent on home oxygen, history of falls
- poor appetite and intake, poor dentition, physically fatigued trying to manage at home, nausea, constipation due to pain medication, ongoing stress with family issues
- admitted to hospital April 2014 with weight of 30 kg, Body Mass Index (BMI) 13, discharged from hospital June 2014 with weight 35.6 kg, BMI 16
- discharged from hospital with services 3 hours per week for shopping and cleaning

Intervention

- initial HACC dietitian visit July 2014 with weight 36 kg, BMI 16
- nutrition support and education on high protein, high energy diet
- budget very tight, continuation of nutrition supplements accessed through Home Enteral Nutrition Scheme and Meals on Wheels as client too unwell to manage meal preparation and unable to eat significant quantities.

Progress

- Gradual improvement in dietary intake and weight over time. Able to participate in pulmonary rehabilitation group, including exercises in October 2014.

Outcomes

- weight improved from 38.2kg, BMI 17 in August 2014 to 43.5 kg, BMI 19 in February 2015
- overall improvement in wellbeing, physical strength
- managing better with Activities of Daily Living
- reduced oxygen requirements and despite intermittent chest infections with COPD has quicker recovery time and decreased requirement for antibiotics.
- dynamometry shows significant improvement in muscle strength over time July 2014 – L 50% / R 46% of predicted level to December 2014 – L 77% / R 76% of predicted level

Overall the combination of nutrition support, physical rehabilitation, home support and psychosocial support has enabled a significant recovery for this lady. Although younger than the CHSP target group she is an example of the success of a multi-disciplinary approach where nutrition has been integral to her reablement.

Case Study 2

85 yr old female referred to HACC dietitian after two month hospitalisation for delirium, aspiration pneumonia, poor oral intake and weight loss

Initial assessment

- lives with husband who is also unwell
- usual weight 63kg, post hospital weight 54kg = 14% loss of weight
- poor oral intake due to pain, fatigue and functional decline

- often missing main meal as unable to prepare due to poor health
- identified as moderately malnourished (SGA-B)
- in home services in place 2.5 hours per week for shopping and cleaning

Intervention

- in addition to nutrition support and education, dietitian suggested meal preparation by in home service provider. Client rejected this option when it was indicated that cleaning hours would be decreased to accommodate this. She preferred that floors be cleaned twice weekly rather than service time being allocated to meal provision
- on follow-up visit client had cancelled all in home services as the service provider had increased fees and she felt it was "too expensive"
- client still accepting of HACC dietitian support (free service) and in home meal delivery service she is unable to manage without in home services
- client's family is now considering nursing home placement even though this is not what the client or her husband are wanting.

The outcome in this case is poor, and relates to the cost of services.

East Maitland Community Health Centre – HACC Intensive Nutrition Therapy Program

Numerous studies have demonstrated the direct relationship between hand grip strength and mortality/ morbidity, as well as increased postoperative complications, increased length of hospitalization, higher rehospitalisation rate, decreased physical status and loss of independence. Studies have also shown that low grip strength in healthy older adults predicts increased risk of functional limitations and disability as well as all-cause mortality. Since muscle function reacts early to nutritional deprivation, hand grip strength is an appropriate marker of nutritional status.

The HACC Intensive Nutrition Therapy (HINT) program offered dietetic evidence-based interventions over a 12 week period with regular contact and focus on achieving and reviewing client generated and directed goals, paying specific attention to the client's desired outcome from their nutrition care. There was a strong focus of regaining and /or improving function and strength through nutrition which was measured by weight gain and grip strength.

All clients who complete the program were:

- referred for unintentional weight loss
- informed of the intervention timeframe and the points of review
- actively involved in the setting of goals particularly nutrition goals and interventions were based on the client's individual preferences, choices and capacity which was then tailored to meet the specific circumstances for the client that allowed flexibility and choice

A summary of the results include:

- 25 clients over the age of 65 years started the 12 week program, nine clients (36% of clients) completed up to six weeks and six clients completed the 12 week program (24% of clients). Reasons for not completing the program included admission to nursing home or hospital, death of client, discharged prior to the 6 or 12 week review due to completion of goals or goals no longer priority for client.
- There was a direct correlation between the increase in kilojoule intake with grip strength

and body weight as shown in the graphs below.

- Of the six participants that completed the 12 week program, two participants had hospital admissions 12 months following the completion of the program and only one client was re-referred to the service after discharge from the HINT program in the following 12 months. The other five participants were not re-referred in the following 12 months post program.
- All clients who completed the 12 week program (with the exception of one which remained the same) had a grade improvement in their malnutrition assessment (SGA) score i.e. moderately malnourished to well-nourished or severely malnourished to moderately malnourished.