Australian Government
Department of Social Services

New Aged Care Short-Term Restorative Care Programme

Policy Consultation Paper

Feedback Template

The Department of Social Services would appreciate feedback on the new Short-Term Restorative Care (STRC) Programme Policy Consultation Paper.

The feedback template mirrors the sections in the Policy Consultation Paper.

Action Required:

1. Please complete the feedback template below.
2. Please expand the response box where necessary.
3. Please return the completed template to STRC@dss.gov.au by **10am Monday 19 October 2015.**

1. Policy context

P3 1.3 DAA supports the concept of Short-Term Restorative Care (STRC) as part of an aged care system which offers a continuum of consumer-directed care options to help older people improve their function, independence and quality of life as their care needs change over time. In the long term it will be desirable that providers of services to consumers for Commonwealth Home Support and other Programmes operate in a framework of restorative care which allows adjustment to meet the needs of consumers at the earliest opportunity. It is also desirable that behaviours and services implemented under an STRC program are continued after completion of the STRC as needed and wherever possible.

There is evidence of malnutrition in the community in older people identified in surveys for people living in their own homes, and also identified during hospital admissions. A 2015 report prepared by DAA for the Australian Commission on Safety and Quality in Health Care identified that older people are at risk of harm from lack of follow-up of malnutrition in discharge planning. Malnutrition is recognised as a factor which contributes to functional decline and accelerates entry to residential aged care.

Dietetic intervention has been shown to improve function, mobility and strength. The Lower Hunter HACC Dietetic Service trialled a short term nutrition care model called HINT (HACC Intensive Nutrition Therapy) where clients were offered a time limited client goal orientated service (6-12 weeks). Results demonstrated positive changes in energy intake, body weight and reduced risk of malnutrition and improved function shown in hand grip strength.

DAA strongly supports approaches which identify malnutrition and inclusion of medical nutrition therapy in STRC Programmes.

2. What is the STRC Programme?

P4 2.3 DAA strongly supports the implementation of multi-disciplinary coordinated services which are goal-oriented and therapy-focussed to reverse and/or slow functional decline in older people with the aim of improving wellbeing. It is important that screening, assessment and intervention for malnutrition and other nutrition issues is an integral part of STRC. Accredited

Practising Dietitians (APDs) are the nutrition experts qualified and credentialed to assess and provide medical nutrition therapy in STRC Programmes. APDs also have a role in leading screening procedures, training and supporting other health professionals and health workers to implement nutrition care which meets the needs of older people.

3. How will the STRC Programme differ to other types of care?

4. How will care recipients be approved to receive short-term restorative care under the STRC Programme?

P5 4.3 It is proposed that eligibility for the STRC Programme will be assessed by Aged Care Assessment Teams (ACAT). DAA would like to see additional training implemented for ACAT to ensure they are able to screen for malnutrition and nutrition related issues, and to refer people to APDs where appropriate for assessment and intervention.

P5 4.4 It is proposed that the assessment for the STRC Programme would lapse six months from the date of the ACAT approval. DAA understands that administrative limits need to be set in the Programme. However it would be of great concern if there were significant delays in implementing the STRC Programme, either because assessment by ACAT was delayed, or because of delays in accessing an STRC Programme. It will be important that STRC Programmes are commenced at the earliest opportunity because early intervention has the potential to slow/delay functional decline.

5. Who will be eligible to receive short-term restorative care under the STRC Programme?

P7 Case study - Helen Russell

As noted in the 2014 *Nutrition and dementia* report by Alzheimer's Disease International

> "Undernutrition is particularly common among people with dementia in all world regions. It tends to be progressive, with weight loss often preceding the onset of dementia and then increasing in pace across the disease course."[1]

Consequently DAA suggests that a comment on nutrition be added to this case study e.g.

> *over the past year Angus has noticed that Helen has been getting more forgetful and was losing weight.*

DAA suggests specific mention be made of therapy to improve nutrition status to enable Helen to respond to the exercises and physiotherapy already included in the case study. Otherwise it is like trying to run a car engine with no fuel in the petrol tank.

> *the Programme provided Helen with exercises and physiotherapy to regain her mobility, and an Accredited Practising Dietitian provided strategies to address Helen's declining nutrition status.*

1. Prince M, Albanese E, Guerchet M, Prina M. Nutrition and dementia - Alzheimer's Disease International 2014.
*https://www.alz.co.uk/sites/default/files/pdfs/**nutrition-and-dementia**.pdf*

p13 Case study - William Symes

DAA would like to see explicit recognition of William Symes' declining nutrition status. Firstly he is described as frail, secondly the bout of gastroenteritis has likely impacted more seriously on William because of poor nutrition status, and the illness and ensuing poor oral intake at that time will further impact on his nutritional status. There is reference to not being strong enough to go past the front gate, not surprising if his food energy intake is lacking. Another case of trying to run an engine with no fuel in the petrol tank.

DAA suggests rewording to say

> *The Programme provided William with the intensive support he needed to recover from his illness, improve his oral intake and strength, and regain his mobility.*

P6 5.6 DAA is pleased to see that Option Two provides for the programme to be available to people who are already receiving care in the home through the home care programme or through a multi-purpose services that is delivering care in the home.

It is not clear in the document how the transition between packages, or the potential for duplication or inadvertent omission of services will be managed. It is important that consumers not be disadvantaged financially or in terms of access to services by moving between services.

Identification of the range of existing services will be needed, and communication between service providers to ensure continuity of existing therapy plans and services. It may not be in the consumer interest to change therapists at all, particularly if the client has dementia. Until MyAgedCare is more stable and performs consistently well, it cannot be assumed that MyAgedCare will support communication by providing the necessary information.

6. How long will care recipients be eligible to receive short-term restorative care under the STRC Programme?

7. How will STRC Programme places be allocated?

P9 7.13.1 Poor nutritional and hydration status is likely to be part of the profile of many people who qualify for a STRC place. DAA considers it is essential that providers are able to provide access to all necessary health care professionals, including APDs, to support integrated multidisciplinary care. If providers do not employ APDs they must be able to say how access to APDs and evidence based nutrition care will be delivered. APDs are qualified and credentialed to provide dietetic and nutrition care to older people with special dietary requirements, nutritionists are not qualified or credentialed to provide this care.

APDs recommend that the nutrition and hydration needs of people are met from food and beverages available in the regular food supply wherever possible. However some individuals will also need oral nutrition supplements, thickened fluid products or enteral nutrition (tube feeding)

products. DAA recommends that these be funded as part of the STRC Programme. APDs report that problems acquiring oral nutrition supplements or other nutrition products limits progress with wellness and reablement programs.

8. What care and services will be required to be provided as part of the STRC Programme?

9. What will be the arrangements relating to subsidy, fees and payments for the STRC Programme?

10. What will be the responsibilities of approved providers of short-term restorative care under the STRC Programme and how will providers be accountable for the delivery of appropriate care and services?

Do you have any other comments or feedback?