

PRODUCTIVITY COMMISSION PUBLIC INQUIRY INTO THE CARE OF OLDER AUSTRALIANS, July 2010.

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This submission is based on results to date from a current ARC project concerned with food services. Malnutrition amongst older people within Australia's aged care facilities are reported to be between 30% -65% (Azad, Murphy, Amos, & Toppan, 1999; Kyle, Unger, Mensi, Genton, & Pichard, 2002; Stratton, Green, & Elia, 2003). Poor nutritional status of older people in care is not widely known nor is it a policy priority. Whilst we can expect older people to have poor nutrition as they move closer to end of their life irrespective of where they live, this differs from the prevalence of malnutrition among older Australians in care. Malnutrition discussed here refers to protein-energy-under-nutrition, rather than over-nutrition and is defined as "a state of nutrition in which a deficiency or excess (or imbalance) of energy, protein, and other nutrients causes measurable adverse effects on tissue/ body form (body shape, size and composition) and function and clinical outcome" (Elia, 2000). Food intake *per se* is the most important risk factor for malnutrition (Paquet, St-Arnaud-McKenzie, Kergoat, Ferland, & Dube, 2003). Older people's quality of life is substantially influenced by the quality of food services in long-term care (Paquet, St-Arnaud-McKenzie, Ferland, & Dube, 2003), as the purpose of foodservice extends beyond the provision of essential nutrients and is a mechanism for choice, control, socialization, connectedness and comfort. The findings from a nationally funded ARC project have identified the interplay and complexity of these multiple issues.

This submission highlights the level of malnutrition and poor nutrition within Australia's aged care facilities and suggests the following contributing factors:

1. the high levels of frailty among aged care residents within Australia
2. the need for frail older people to receive assistance with eating
3. the links between poor nutrition and levels of staff time and knowledge for this task,
4. the need for adequate funding to support appropriate care at meal times
5. the risk management culture prevalent across the sector, and
6. the impact of the current regulatory regime on nutrition

1. The frailty of older people in care

Aged care facilities now provide care for older Australians with a level of frailty that is unprecedented. Not only are people moving to aged care with higher levels of frailty but levels of care required for residents is proportionally higher. Whilst current figures substantiating this point are not available (latest AIHW reports are based on 2006 data) our research concerned with food services in aged care facilities show 70% of assessed residents require feeding assistance, a clear measure of frailty.

2. The need of frail older people to receive assistance with eating

The nature of the feeding dependence revealed a pattern that residents are largely reliant on staff; nearly all were moderately or heavily relying on staff during mealtimes. A lack of assistance at mealtime to feed multiple residents, particularly residents with multiple sensory and cognitive impairments contributes to care staff having a task orientation rather than a person orientation. It is difficult for staff to view feeding dependent people as an opportunity to sustain relationships in this context.

3. Linking staff time and knowledge around assistance with eating with nutritional outcomes

Consistent with assertions by the aged care industry of the competing demands on care staff time within facilities, this research has found a direct effect on the nutritional intake of residents. Individual staff are consistently observed to have to provide eating assistance and support for up to seven residents at meal time. In addition many other frail residents were observed to have marginal abilities to independently feed and could have benefited from some assistance, yet were not provided any due to high demands of the large numbers of residents with full dependence needs.

The high proportion of residents with swallowing or behavioural issues results in considerable challenges in the effective provision of assistance with eating meals. Staff experience competing demands and stress at meal times. From our observations a quarter of the feeding assistance provided was considered not ideal as a consequence, due to multiple

issues including mass presentation of all food items simultaneously, feeding in a rushed manner, and complete lack of any social interaction with the resident during food intake.

Staff have approached researchers on the project to seek knowledge and understanding of feeding residents with special needs. The complexity associated with supporting and assisting people who are frail or experiencing dementia alongside respecting people's choice not to eat at the end of their life requires sophisticated knowledge and skills. These skills are largely unrecognised by the sector, and require appropriate training as well as the provision of adequate staff levels within facilities to ensure person centred care. Funding levels do not permit a reasonable level of care and this is clearly evident in the unsatisfactory feeding assistance received by residents within Australia's aged care facilities.

An important consequence of the lack of staff time is the amount of food that is wasted. Up to 50% of food presented was observed to be wasted. There is a connection between high staff demands and food wastage, in particular serving food that has become cold, food mixed together on a plate in an unappetizing way, rushing intake and lack of time to assist other frail, yet less dependent residents who could benefit from some assistance to facilitate improved intake.

4. Families role in aged care facilities

Families and friends can and do play a central role in the care of older people within aged care facilities. Whilst people in aged care may not have family, most do. Families have been observed to provide crucial assistance at meal times not only assisting their family member with their meal but also helping with the meals of other residents. This has been observed with residents experiencing dementia or frailty. It is often overlooked within discussions about aged care provision of the pivotal role families play in the well being of their family member as well as other residents.

However facilities can be unwilling to allow families to participate in the same way that they would have before their family member entered care. The regulatory regime surrounding aged care facilities does suggest to providers they take a risk if they support families to provide personal care in the areas such as feeding. Clearly it would be desirable for staff to assist or support family's knowledge base in this area.

5. Risk management culture

From our observations and studies in the residential aged care setting as part of our research , the approach towards diets and texture modifications is in part one of risk management. Observations of textures of meals revealed that even the “normal” i.e., the non-texture modified meals, were comprised of predominately soft textures, (e.g., minced meat with mashed vegetables). While softer consistencies are easier to manage for individuals with dentition and fatigue issues, the lack of texture can be unappealing and the “sameness” of softened and mashed foods over days discourages interest in food intake. While this blanket softening of all meals would appear to be a response to managing the overall frailty of most residents, it does result in those who are able to manage a greater range of consistency in foods being denied that variety. In the absence of adequate staffing to assist individual residents, it appears that a “group approach” to meal textures is adopted, thus minimizing overall risk but at the same time limiting and reducing food choice for some.

Given the importance of food quality to overall foodservice satisfaction and food intake, menus should focus on maximizing flavor and minimizing nutrient restrictions and texture modifications that almost always limit the provision and enjoyment of flavorsome foods, for example, crumbed fish and/or chips; bacon and eggs; egg and/or cheese-based dishes; gravy; sauces; creamy desserts. Although intended to prevent aspiration and asphyxiation in residents with dysphagia or impaired swallowing, texture modified diets have reduced sensory qualities, reduced palatability, and lower nutritional quality than regular diets and are associated with reduced food intake, malnutrition and dehydration (Brownie, 2006; Wright, Cotter, Hickson, & Frost, 2005). These effects are heightened when the food/meal is unidentifiable. This is a serious issue for a group where 30-65% is already malnourished therefore these diets should only be used when absolutely critical. The unpalatable nature of the food clearly contributed to the 50% food wasted.

Suggested action

Ensuring aged care providers can provide appropriate nutrition within a person centred model requires various policy and practice responses. Food matters to older people, not only in terms of enjoyment but provides a mealtime ritual, a structure to their day and social contact.

There is a need for societal and policy structures to respect the key significance of food for older people living in aged care facilities.

The funding of aged care facilities needs to ensure:

- Staff have time to provide a more relaxed and sociable meal time with each resident
- Staff have the training in relation to particular needs of their residents including dysphagia and people who are refusing to eat

The regulations pertaining to aged care facilities need to:

- Encourage and support family assistance at mealtimes
- With adequate funding facilities would not find it necessary to present food in a 'lowest common denominator' form to reduce risk.

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