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Exploring the Canadian Long Term Care Dietitian Workforce

Karly Bartrim, 2023

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Table of Contents

1. Acknowledgments

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2. Executive Summary

Australia's ageing population is placing increasing pressure and demand on aged care services. The recent Royal Commission into Aged Care Quality and Safety revealed reforms were needed for the workforce caring for older adults and the nutrition care provided in Residential Aged Care Facilities (RACFs). Dietitians are university trained health professionals who can provide expert nutrition and dietary advice to improve older adults health and quality of life. Recent studies conducted in Australia have shown that significant change is required to improve the dietitian workforce, dietitians individual practice and policy in the aged care sector to ensure all older adults living in RACF receive high quality care nutrition care and services.

The overall aim of the Nutrition in Aged Care Fellowship was to understand the Canadian dietetic workforce in LTC. Specifically questions aimed to explore 1) the role of a dietitian in LTC, 2) LTC homes and the regulations and legislations set by the ministry including the staffing workforce and the role food and nutrition plays, 3) the recent workforce initiatives conducted to improve LTC dietitian workforce. The Fellowship travel was undertaken for one month around the Provinces of Ontario and British Columbia, Canada.

Karly is an Aged Care Accredited Practising Dietitian (APD), Lecturer at Griffith University and is a current PhD Candidate at The University of Queensland. Through working as a dietitian in over 15 residential aged care facilities, she has recognised the importance of dietitians working with older people. This inspired her to start her PhD, exploring dietitians working with older adults in residential aged care facilities.

The Fellowship methodology utilised a skill enhancement approach to explore the dietitian workforce and their role in LTC homes. The Nutrition in Aged Care methodology's findings are reported in three key sections; 1) the dietitian role, which includes learnings on mandated dietitian hours, Best Practice Guidelines, reviewing residents, dietitians role in food service and dietitians integration into the LTC, 2) LTC home environment and legislation, such as small dining rooms, highly trained and regular staff, resident care and monitoring and food provided and 3) recent advocacy and research in LTC.

The Nutrition and Aged Care Fellowship has been and will continue to be instrumental in developing the Fellow as an early-career researcher. Through this Fellowship, the Fellow has established connections, expanded her research network and has had the opportunity to build world-class knowledge from experts in the field. Specifically for aged care research, most of the research currently stems from Canada. The knowledge and research connections the Fellow has developed can translate into additional research projects, grants, and career opportunities – all favourable for personal and professional career goals. The Fellow is determined to use the knowledge to create positive change within the aged care setting through world-class research projects and collaborating with governing bodies.

The Fellow has been working hard to disseminate learnt knowledge, to make change and impact in the sector. Several dissemination strategies have been undertaken or are upcoming. Dissemination strategies can be summarised in four key areas presenting to Dietitians Australia and RACF Dietitians, sharing learnings in published research articles, blog posts and on social media, presentations and networking at conferences and teaching nutrition and dietetics students.

Canada is world-leading in strengthening the dietetics workforce to maximise the quality of care provided to older adults in LTC homes. The LTC dietitian workforce have designed and implemented initiatives targeted at dietitians. This Fellowship, has allowed the Fellow to recognise and build experience from those initiatives and apply that understanding in Australia. The knowledge gained will assist in developing policy and advocacy strategies for the Australian context. The Fellow makes the following recommendations and considerations; regular dietitian reviews for all residents living in RACF, more nutritious food assessed by dietitians to be provided in aged care, improvement of RACF systems, processes, and mandatory reporting, strengthening the dietitian workforce and more research conducted in Australia on topics including nutrition and dementia, nutrition and food policy, malnutrition, improving food intake in RACF, staff training and knowledge in older adults' nutrition care and mealtimes and the dining experience. These recommendations must be implemented to improve the equity of care older adults receive in Australia. All older adults deserve to receive high quality nutrition care to improve their health and overall quality of life.

3. Fellowship Background

Australia's ageing population is placing increasing pressure and demand on aged care services.[1] By 2050, an estimated 3.5 million Australians will be consumers of aged care services.[1] Aged care services include Home Support, Home Care and Residential Aged Care Facilities (RACF).[2] The 2021 Australian Royal Commission in Aged Care Quality and Safety highlighted the need for high-quality care for all older people.[3] An essential action to achieve this is strengthening the workforce that cares for older adults.[3] One specific recommendation was employing allied health professionals, including dietitians, in RACF.[3]

Dietitians are health professionals with four to five years of university training who can provide expert nutrition and dietary advice.[4] Dietitians' role in aged care is to optimise nutrition and hydration to support a good quality of life and overall health for older people.[5] Dietitians can do this by providing one on one nutrition advice to older adults, being involved in food service and other roles such as educating staff members or nutrition audits.[5] Despite the recognised input dietitians can have in RACF, in Australia, there is no mandated requirement for dietitian services. As such, aged care facilities choose to enlist a dietitian service or have a dietitian contracted to the facility or visit on an ad hoc basis. Each aged care facility may pay for the dietitian service or charge the resident for seeing a dietitian.

Dietitians Australia (the governing body for Dietitians) has continued to advocate for dietitian services to be in all RACF. Extending on the recommendation from the Royal Commission in Aged Care Quality and Safety, Dietitians Australia has announced that one dietitian must be engaged for at least one hour per month per resident.[6] The hour recommendation was based on clinical indications and mandated hours established in Ontario, Canada.[7] As such, these recommendations will require the RACF dietitian workforce in Australia to grow in size and capability.

To better understand the dietitian workforce nationally and internationally, several research projects have been completed within the last two years. In addition, with a potential increase in the dietetic workforce, it is important to understand the dietitians knowledge, skills and attitudes and their experiences in the workforce. Recently, an integrative review was published examining dietitians' knowledge, skills and attitudes regarding working with older adults in residential aged care facilities and home care services.[8] It concluded that dietitians have mixed attitudes working with older adults.[8] More specially, it found five main themes; 1) recognising their contribution as dietitians, 2) lacking clarity about the boundaries of their role, 3) all team members have a role to play in nutrition care, 4) assumptions and biases about working with older people and 5) needing to build capacity in the workforce.[8] While the study aimed to explore knowledge and skills there was insufficient literature to conclude a finding.[8] It is essential to mention that three of the seventeen studies included were published in Canada.[8]

As such, a national survey with Australian dietitians was conducted to understand dietitians' confidence in their knowledge and skills working with older adults.[9] The survey found that RACF and HCS dietitians are confident in most aspects of their role.[9] However, the survey revealed opportunities for dietitians to be better supported and integrated into RACF.[9] Developing the confidence of higher-level systems and communication in early career dietitians is needed.[9]

10 To further understand factors associated with poor role integration in RACF and confidence of knowledge and skills, interviews conducted with 31 Australian dietitians.[10] The findings highlighted priority areas to improve the RACF dietitian workforce and, more importantly the aged care sector.[10] The study found five themes 1) joining the aged care workforce was not initially considered a career option, 2) difficulty sustaining satisfaction working in aged care, 3) navigating practical challenges working with residents while prioritising quality care, 4) poor acknowledgement of the dietitian role by staff and 5) grappling with a moral desire to improve the aged care sector.[10] Overall, the findings of this study highlighted the need for initiatives to support dietitians working in RACFs to maximise their potential positive impact.[10]

The three studies conducted in the last two years provide evidence that significant change in the dietitians workforce and dietitians individual practice and policy in the aged care sector is imperative. It is necessary to explore international examples to identify priority areas for improvement and develop insight into how changes can be made.

Fellowship context

The overall aim of the Nutrition in Aged Care Fellowship was to understand the Canadian dietetic workforce in LTC. Specific questions to explore 1) the role of a dietitian in LTC, 2) LTC homes and the regulations and legislations set by the ministry including the staffing workforce and the role food and nutrition plays, 3) the recent workforce initiatives conducted to improve LTC dietitian workforce.

Whilst most of the Fellowship report describes information specific to the Ontario province, some references may be made to the province of British Columbia.

Fellowship methodology

The Fellowship was conducted through in-person interviews, attending group presentations/ workshops, LTC site visits, virtual meetings via Zoom or Microsoft Teams and email.

Fellowship period

The Fellowship was undertaken for one month, from the 4th of November to the 4th of December

2022. Karly travelled to Toronto, Ottawa, Montreal, Waterloo, London in Ontario and Vancouver, New Westminster and Tsawwassen in British Columbia, Canada.

Fellow biography

Karly is an Aged Care Accredited Practising Dietitian (APD), Lecturer at Griffith University and is a current PhD Candidate at The University of Queensland. She completed her Bachelor of Nutrition and Dietetics (Honours) at Griffith University.

Through working as a dietitian in over 15 residential aged care facilities, she has recognised the importance of dietitians working with older people. This inspired her to start her PhD, exploring dietitians working with older adults in residential aged care facilities. She hopes this research is only the beginning of a lifelong research career inspired to improve the aged care sector and support dietitians.

Karly is a member of Dietitians Australia, Australian Association of Gerontology and Australian & New Zealand Association for Health Professional Educators.

Abbreviations / Acronyms / Definitions

- **RACF- Residential Aged Care Facilities (Australia)**
- **LTC- Long Term Care (Canada)**
    - *Residential Aged Care Facilities and Long-Term Care Homes are for older adults who can no longer live safely in their own homes. These facilities or homes include accommodation and 24-hour care.*
- **Dietitians** are university trained health professionals who provide expert nutrition and dietary advice.
    - In Australia, Dietitians working in RACF must be registered with Dietitians Australia. Dietitians registered in Australia are known as **Accredited Practising Dietitians (APDs).**
    - In Canada, all practising dietitians must be registered with the College Associated with their Province. For example, in Ontario Canada, dietitians will be registered with the College of Dietitians of Ontario. Dietitians in Canada are also known as **Registered Dietitians (RD).**
- **DA- Dietitians Australia**
    - Dietitians Australia is the governing body of dietitians in Australia.
    - **DC- Dietitians of Canada**
    - Dietitians of Canada is an organisation supporting dietitians in Canada.

4. Fellowship Learnings

The Fellowship methodology utilised a skill enhancement approach to explore the dietitian workforce and their role in LTC homes. The Nutrition in Aged Care methodology's findings are reported in three key sections; 1) the dietitian role, 2) LTC home environment and legislation and 3) recent advocacy and research in LTC.

Dietitian Role

Mandated Dietitian Hours

In 1998, the mandated dietitian requirement of 15 minutes per resident per month in Ontario, Canada, was enacted. The mandated hours were increased to 30 minutes per month in 2010. In Ontario, it allows for dietitians to be in LTC regularly, often at least once per week. For example, a dietitian working in a 90-bed home would be allocated 45 hours per month, allowing for ~6 hours two days a week. At some LTC, they may have more allocated time, e.g., at Apotex Centre at Baycrest, 45 minutes per hour (as they may not have a Food Nutrition Manager). Whilst Ontario is the only province with mandated hours, dietitians do appear to have a regular role in LTC in other provinces. Some dietitians interviewed in LTC in British Columbia also had approximately 30 minutes per residents per month, whereas others had less.

Best Practice Guidelines

The Best Practices for Nutrition, Food Service and Dining in LTC Homes Working Paper[11] guide dietitians in Ontario. It was created by the Ontario LTC Action Group, with the most recent version being published in 2019. The working paper has five components: 1) organisation and administration, 2) menu planning, 3) food production, 4) nutrition and hydration care and 5) meal service and pleasurable dining.[11] According to the working paper, best practice is achieved by meeting the goals of all five sections.[11] Dietitians interviewed in Ontario stated they use the working paper regularly, and it assists with guiding their role and supporting the LTC they work.

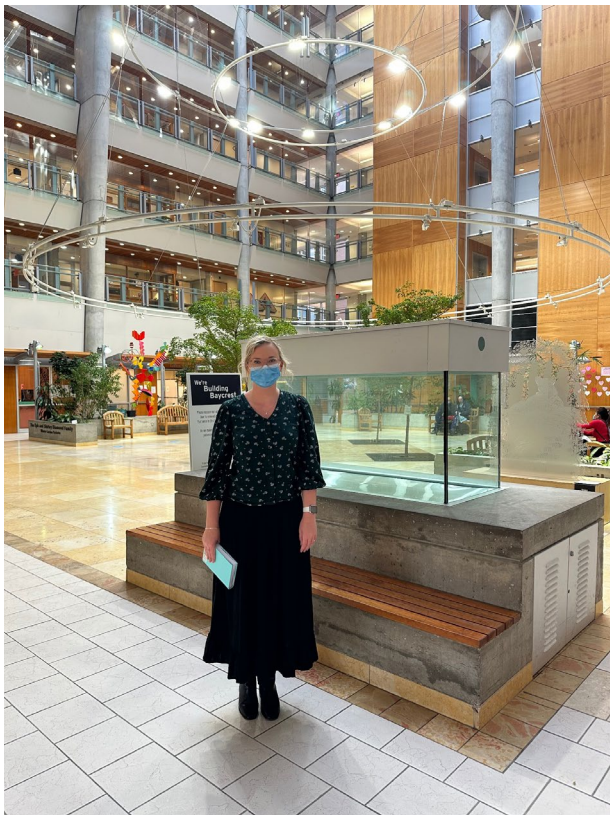

Figure 1. Fellow at the Apotex Centre, Baycrest Toronto

Reviewing Residents

In Ontario, the dietitian will review a resident on admission to complete a nutrition assessment. A case conference of the resident will be conducted six weeks after admission. The Resident Assessment Instrument (RAI) RAI-MDS 2.0 is completed quarterly for each resident and submitted to the Ministry of Health. Section K is often completed by the dietitian (occasionally the Nutrition Manager). It has six sections: oral problems, heights and weight, weight change, nutritional problems and parenteral or enteral intake. Another case conference is also completed annually. In addition to these regulations set by the Ministry of Health, residents are reviewed based on nutrition risk and as clinically required. Dietitians will review a resident on admission and often determine their level of nutrition risk as high, moderate, or low. According to the Best Practices for Nutrition, Food Service and Dining in Long Term Care Homes, it is recommended that high risk residents are reviewed at least monthly. Review of moderate or low risk is home dependent, and the dietitian may also receive assistance from the Nutrition Manager for screening or reviewing low risk residents. Clinical indications for referrals include but are not limited to; skin integrity (will often be referred for any issues with skin e.g., sunburn through to skin tear or pressure injury), weight loss, hydration- 3 days of not meeting specified fluid about (can vary home to home- often 1000mL-1750mL), poor appetite, palliative/end of life care etc. Due to a shortage of Speech Language Pathologists in Canada, most dietitians working in LTC have been trained to do swallowing assessments (with complex swallowing concerns referred to a Community Speech Language Pathologist). As such, swallowing assessments take up a moderate proportion of the dietitian's role. Dietitians are also required to complete the nutrition care plan for every resident.

Role in Food Service

Dietitians in Canada also have a significant role in food services. In Ontario, dietitians must sign off the menu, before the home can use it. If the Ministry of Health audits a LTC, they must show that the audit is complete. The dietitian is required to complete a nutrient analysis, which includes assessing the menus nutrition content and ensuring it meets older adults' requirements. It is a requirement that there are choices at lunch and dinner and that the cultural preferences of individuals are considered. Texture modified meals must be the same as the regular menu rotation. All menus, including texture modified and therapeutic diets (e.g., gluten free, vegetarian), are analysed by electronic nutrient analysis and meet the nutrition needs of the majority in care. Any gaps in nutrients are identified and plans to address gaps are developed. The menu must have the following average daily nutrient targets (based on the full menu cycle); energy 2000kcal, protein 100g, dietary fibre 30g, fluid 2000mL, sodium 3500mg or less, vitamins and minerals to be 100% of Dietary Reference Intakes. Moreover, the menu cycle in LTC in Ontario must be at least three weeks. Unique to Ontario, residents must be able to choose at the point of service, and they must be offered two options.

Integration into the LTC

Through observations, it is evident that dietitians know all the residents in their LTC well. Mandated and regular time onsite, allows dietitians to observe mealtimes and more generally be present onsite. It was clear that dietitians knew all residents well, as residents were greeted by first name when walking throughout the LTC home, and the dietitian was able to provide insight into the clinical needs and also preferences of every resident. In addition, more time has allowed dietitians to know staff better and build meaningful working relationships, which is fundamental for team success.

LTC Environment

Small Dining Rooms

An observational contrast noted at LTC visited was the dining environment. Only one of the six LTC visited had a large dining seating area, with all others having multiple dining rooms of at most 20 residents (requirement of 36 or less by the Ministry of Health). As such, the dining rooms appeared calmer and quieter. In majority of the LTC homes attended, they also had a kitchen or servery attached to the dining room.

Highly Trained and Regular Staff

The level of support dietitians receive from staff was highly noted. As previously indicated, Nutrition Managers often work very closely with LTC dietitians. It is a requirement of the Ministry of Health that one Nutrition Manager is employed at every home.[12] The Nutrition Manager must be an active member of the Canadian Society of Nutrition Management or a registered dietitian.[12] For Nutrition Manager working hours, the minimum number of hours per week shall be calculated as follows:[12]

$$M = A \times 8 \div 25$$

"M" is the minimum number of hours per week, and

"A" is,

(a) if the occupancy of the home is 97 per cent or more, the licensed bed capacity of the home for the week, or

(b) if the occupancy of the home is less than 97 per cent, the number of residents residing in the home for the week, including absent residents.

The Ministry of Health requirements regarding food preparation is that at least one cook works at least 35 hours per week in that position on site at the home.[12] The cook or chef must be appropriately trained with a certificate or diploma outlined by the Ministry of Health.[12] A regular cook or chef allows for continuity and consistency of food preparation within the LTC home.[12]

Requirements also exist for Food Service Workers.[12] The minimum staffing hours of Food Services workers are calculated as follows:

$$M = A \times 7 \times 0.45$$

where,

"M" is the minimum number of staffing hours per week, and

"A" is,

(a) if the occupancy of the home is 97 per cent or more, the licensed bed capacity in the home for the week, or

(b) if the occupancy of the home is less than 97 per cent, the number of residents residing in the home for the week, including absent residents.

All Food Services Workers must complete a Food Service Worker Program or undergoing/ successfully completed cook training.[12] The Food Service Workers role is to assist in the preparation of resident meals and snacks, distribution and service of resident meals, the receiving, storing and managing of the inventory of resident food and food service supplies; and the daily cleaning and sanitising of dishes, utensils and equipment used for resident meal preparation, delivery and service.[12]

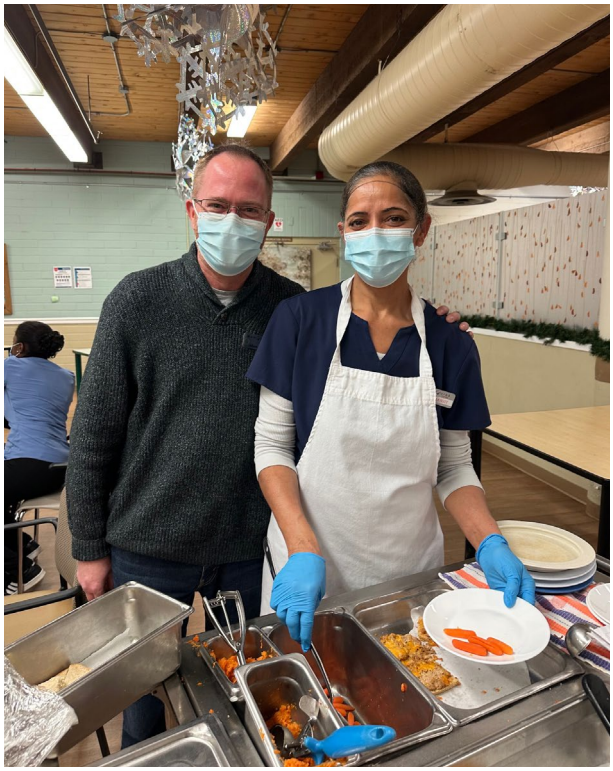

Figure 2. Staff serving the lunch meal at Kin Village

Resident Care and Monitoring

Notably, resident care in Ontario LTC homes is of a high standard which puts residents needs first. It was apparent that residents receive high quality care which is required to

meet their complex care needs especially when entering LTC. One challenge Ontario is currently facing is a shortage of LTC beds, and as such, there is a long wait to enter a LTC home. Discussion with dietitians reported that the consequence of this is that residents are entering LTC frailer, often malnourished and therefore have higher care needs. Similarly, it is important to note that ~70% of residents living in LTC have been diagnosed with dementia[13], which is much higher than ~54% in Australia RACF.[14] Dementia residents often have higher care needs, therefore adding to LTC home care requirements.[15]

Most importantly, LTC homes ability to regularly monitor and support residents health and nutrition was highly noteworthy. In LTC homes attended, all resident's food and fluid were measured throughout the day. Clear documentation of food and fluid allows the dietitian and other care or nursing staff to regularly monitor for any changes in consumption and reduce the risk of consequences of lack of consumption, e.g., dehydration or malnutrition. Moreover, effective resident monitoring is also seen through the number of risk tools utilised such as Cognitive Performance Scale (CPS), Changes in Health, End-stage Disease and Signs and Symptoms (CHESS), Pressure Ulcer Risk Scale (PURS) and Fracture Risk Scale (FRS). Such tools allow for ongoing monitoring and assist the dietitian in recognising any potential signs of nutritional inadequacy.

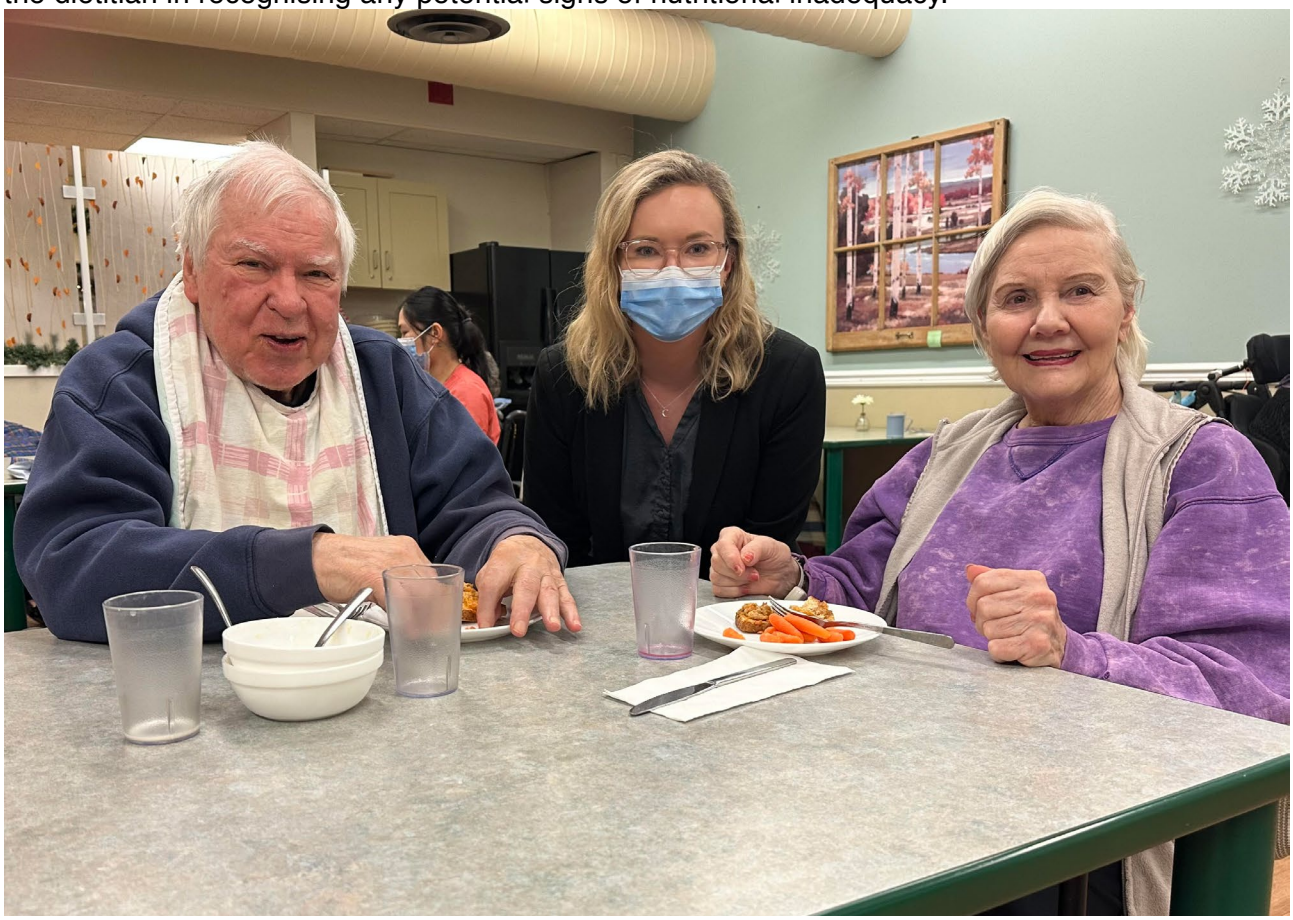

Figure 3. Fellow with two residents eating their dinner at Kin Village

Food Provided

As previously mentioned, it is a legislated requirement by the Ministry to ensure high quality nutritious food is served in all LTC homes in Ontario. The served food in LTC homes visited appeared to be of high quality, with the majority of residents enjoying the meal. A particular LTC home serving food worthy of noting is Kin Village in Tsawwassen, British Columbia. Compass Group Canada has recently incorporated novel practices to create Texture Modified Meals onsite. Typically, most homes in Canada and Australia may need to add several ingredients and undergo processes to form the right texture. At Kin Village, however, they can make meals fresh onsite with their processes and moulds are used to create a realistic look to the original food. Since conception, staff report they have had great feedback from residents and their families and often reported that residents consume more food.

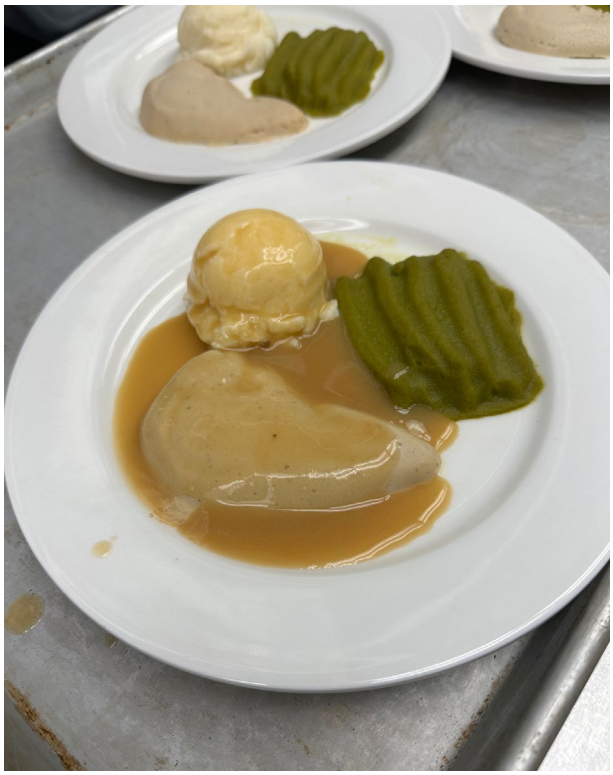

Figure 4. Texture Modified Meal Created by Compass Group Canada Served at Kin Village

Systems

Effective systems within LTC homes assist the dietitian in conducting their role effectively and efficiently. Notability in Ontario, having the same computer system in all LTC homes, has key advantages. For dietitians working across a few homes, it allows for ease of use and provides familiarity. In addition, the system is built to automatically send coding to the Ministry for quarterly and other requirements therefore saving time and additional administration steps.

Advocacy

For almost three decades, dietitians have advocated for strong workforce regulations in LTC homes. In 1998, the dietetic mandated 15mins per resident ratio came into effect. Two key contributors and critical advocates, Paula Blagrave and Christine Barker, they shared important ideas which helped this mandate come to fruition. For example, having a solid working group to make noise and advocate for change, having a strong dietetic business to show how the standards could be met and regularly meeting with the Ministry to push for change. Since then, in 2010, the mandated ratio increased to 30mins, which still stands today.

More recently, two key working groups Ontario Seniors Nutrition & Advocacy Committee (OSNAC) and the Food and Nutrition Advisory Team (FNAT) and the Gerontology Network, Dietitians of Canada group, continue advocating for changes to the LTC dietetic workforce.

The most relevant work that OSNAC and FNAT have been working on is advocating for an increase in the mandated dietitian ratio. Using similar approaches to colleagues in 2010, they hope to have 45 minutes per resident of dietitian time mandated. More mandated time is only one of many other tasks the group is currently working on. Other items include Updating Clinical Practice Guidelines advocating for increased hours for other nutrition and food staff e.g. Chefs.

The Gerontology Network, Dietitians of Canada, have also been advocating for changes in LTC. Most recently, researchers have conducted a scan of international guidelines for long term care as well as an environmental scan of dietitian practices across Canada. This research aims to help inform National LTC guidelines for dietetic practices and food and nutrition in LTC. As Ontario is ahead of other Provinces, it is hoped that this advocacy work will allow all older adults across Canada to receive similar care.

Figure 5. The Fellow with world-renowned Gerontologist, Older Adult Advocate and CEO Kin Village, Dan Levitt and Support Services Manager Compass Group Kin Village, Adam Henry

Research

Canada has been leading the way in nutrition and food-related research with older adults, particularly in LTC and the dietetic workforce. A significant contribution to the research is pioneered and led by Heather Keller Professor of Schlegel Research Chair Nutrition and Ageing Lab at the University of Waterloo.

Well recognised research from Keller and her team is the Making the Most of Mealtimes (M3) study, which "aimed to understand the associations between inadequate food and fluid intake among older adults living in LTC and the multi-level influences, and multi-factorial causes of this intake, which can lead to malnutrition within this population"[16] and CHOICE+ Making the most of mealtimes which is "an innovative program that aims to improve the mealtime experience for residents in long-term care."[17] The M3 study provided insight into determinants of food intake in LTC, with CHOICE+ providing ideas and solutions to potential challenges at mealtimes. Most recently, Heather et al (2022), published an article titled Reimagining Nutrition Care and Mealtimes in Long-Term Care.[18] In the special article, Keller and colleagues explored evidence-based recommendations for nutrition care processes, food and menus, eating assistance, and mealtime experience, to provide actions for implementation and ratings on their feasibility.[18] All research conducted by Heather and team, is imperative to improve practice in Canada and Australia.

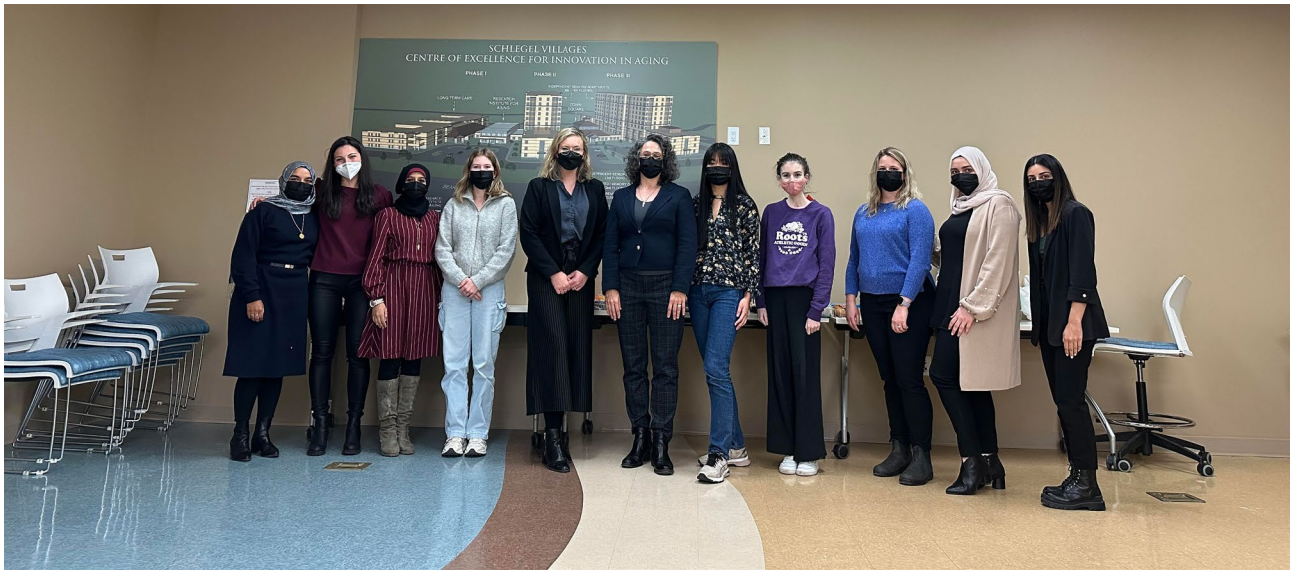

Figure 6. Heather Keller and Team Members at the Nutrition and Ageing Lab

5. Personal, professional and sectoral Impact

Personal and Professional

The Nutrition and Aged Care Fellowship has and will continue to be instrumental in developing the Fellow as an early-career researcher. The Fellow has a personal mission to bring about tangible positive change within the aged care setting and improve the quality of life for older people through nutrition. The Fellows goal is to become a full-time researcher to improve the aged care workforce continually.

An essential aspect of early-career research is the development of networks with experts within the field. Through this Fellowship, the Fellow has established connections internationally which has expanded her research network and allowed the Fellow to continue to build world-class knowledge from experts in the field. Specifically for aged care research, most of the research currently stems from Canada. The knowledge and research connections the Fellow has developed can translate into additional research projects, grants, and career opportunities – all favourable for personal and professional career goals. The Fellow is determined to use the knowledge to create positive change within the aged care setting through world-class research projects collaborating with governing bodies.

Sectoral Impact & Dissemination of Knowledge

To make change and impact in the sector, the Fellow has been working hard to disseminate key learnings from the Fellowship. A number of dissemination strategies have been undertaken or are upcoming.

1. Presenting to Dietitians Australia and RACF Dietitians

Soon after returning from Canada, the Fellow met with Media Manager, Advocacy and Policy General Manager and Senior Policy Officer (Aged Care) from Dietitians Australia. In this 30-minute meeting, the Fellow could share her learnings from Canada and, most importantly, relate learnings to their current advocacy areas (incorporate mandated malnutrition screening and annual The Menu and Mealtime Quality Assessment). Further discussion was had around future considerations and plans to incorporate the whole scope of the dietitian in RACF.

The Fellow will also meet with a range of dietitians working through events, future planned research, and the Dietitian Australia Conference. During these opportunities, the Fellow will share key learnings from the Fellowship and, most importantly, inspire dietitians to advocate for change.

2. Research Articles and Blog Posts

The Fellowship allowed the Fellow to increase her global knowledge of other dietetic practices.

As such, aspects of knowledge learnt has featured and will continue to be featured in a number of journal articles or blog posts. Reference to Ontario dietitian working hours has been mentioned in a number of papers by the author and will continue to be referenced in soon to be published papers. Blog articles have also incorporated information learnt, such as the blog post in January for Aged Care Research & Industry Innovation (ARIIA) Knowledge and Implementation Hub and an upcoming article to feature in Australians Ageing Agenda.

3. Presentations and Networking

In 2023, the Fellow plans to share her new knowledge to make changes in the sector. The Fellow is attending three conferences this year, including Aged Care Research & Industry Innovation Conference, Dietitians Australia Conference and Australian Association of Gerontology Conference. Whilst not presenting fellowship findings directly, the Fellow will incorporate elements of her learnings in her presentations and networking with other dietitians, researchers, older adults and advocacy members.

Moreover, the Fellow regularly shares what she has learnt in Canada, in her current role as a Lecturer, which includes taking student dieititans to RACFs. She shares dietitians stories of their practice in Ontario and also discusses the opportunities for the future of RACF. Most importantly, the Fellow hopes to inspire future dietitians to consider a RACF career path and continue to advocate for a significant dietitian role in RACF.

4. Media

The Fellow has continued to post about her Fellowship and learnings since returning from Canada. She has shared on Social Media platforms, Linked In and Twitter. The Fellow plans to continue to post on social media to spread awareness of the dietitians role and the importance of change in the sector.

The Fellow also continues to speak with Dietitian Australia and journalists to share her learnings from Canada.

6. Recommendations and Considerations

Canada is world-leading in strengthening the dietetics workforce to maximise the quality of care provided to older adults in LTC homes. They LTC dietitian workforce have designed and implemented initiatives targeted at dietitians. By undertaking this Fellowship, it has allowed the Fellow to recognise and build experience from those initiatives and apply that understanding in Australia. The knowledge gained will assist in developing policy and advocacy strategies for the Australian context. After exploring effective examples, Australian initiatives are more likely to be successful.

In the Australian context, several recommendations could be made to improve the dietetic workforce through changes in the RACF sector and strengthening the dietetic workforce. It is important to acknowledge that changes at the Government level will take time. Given this, the Fellow makes the following recommendations and considerations:

Better Integration of the Dietitian and their role in RACF

1. Regular dietitian reviews for all residents living in RACF

Currently in Australia for most dietitians, residents are only reviewed on an “as required” basis. The Fellow encourages the Government to incorporate RACF requirements to be similar to those in Canada. The Fellow recommends:

- Introducing a mandate to ensure all residents are seen at least on admission and quarterly. To do this the Government will need to support RACFs to employ or regularly contract dietitians.
- The Government should consider incorporating a mandated hour ratio to further support the diverse role of the dietitian, such as training staff, conducting audits and supporting residents beyond clinical.

To achieve such recommendations, a strong working group of dietitians will need to be established. A working group similar to those established in Canada (OSNAC and FNAT, and the Gerontology Network) will allow dietitians to work together to create noise in the advocacy space.

2. Nutrition in aged care

Since the Royal Commission into Aged Care Quality and Safety and media reports following, it is evident there needs to be a change to the food provided in RACF. All food delivered in RACF needs to be of high quality and meet residents’ nutrition needs and preferences. Moreover, improvements must be made in the preparation, delivery of food and the whole dining experience. As such, the

Fellow recommends:

- Introducing mandated requirements for dietitians to be involved in menu planning and complete the annual The Menu and Mealtime Quality Assessment.
- Create best practice national guidelines for meals and menus.

Like the first recommendation, developing a strong working group including dietitians is imperative to design and implement such guidelines. A review of state guidelines and standards for menus and research in RACF is required to design evidence-based guidelines that will become national legislation.

3. Improving RACF systems, processes, and mandatory reporting

Following the Royal Commission into Aged Care Quality and Safety, it is evident RACFs in Australia require major reform.

Improvements required in the sector have been noted in the Fellows previous research, through reflections of the Fellowship and seeing examples in Canada.

While there are many recommendations the Fellow could make to improve this area, the focus will be on priority areas of RACF that have a significant influence on the residents nutrition and the dietitians role.

The Fellow makes the following recommendations:

- Create a standardised software or program for all RACFs to utilise. In the software or programs, it needs to ensure the data can be easily populated and submitted directly to the Commission. A standardised method will allow for faster processes and reduce the workload of staff.
- Ensure all RACFs across Australia have standardised nutrition policies and procedures that are negotiated with the RACF staff and a dietitian.
- Incorporate malnutrition screening quarterly and assess nutrition factors such as average oral intake, supplement use, medication use, chewing or swallowing concerns and assistance during mealtimes and clinical conditions increasing nutrition risk, monthly to the Quality Reporting Indicators.

4. Creating a strong dietitian workforce

In Australia, it has been incentivised that dietitians in RACF need to be more integrated and better supported. Initiatives at a professional or workforce level are required, and the following are

recommended by the Fellow:

- Develop a best practice guideline (similar to Dietitians of Canada Best Practices for Nutrition, Food Service and Dining in Long Term Care Homes) or handbook. A guideline or handbook will allow all dietitians to access evidenced based information to support them in their role.
- Create a National support program for RACF dietitians to connect and assist one another. Events, opportunities to collaborate and mentorship must be key features of the program.

5. Research

The research into aged care in Australia needs to be improved, especially in regards to nutrition and the dietitian workforce. Research into best practice areas in all areas of RACF is needed. With a specific focus on nutrition, the Fellow recommends research in the following areas:

- Nutrition and dementia
- Nutrition and food policy in RACF
- Malnutrition in RACF
- Improving food intake in RACF
- Staff training and knowledge in older adults' nutrition care
- Mealtimes and the dining experience

7. Conclusion

There are many opportunities to improve the Australian dietitian workforce and the wider RACF sector. Canada has world-leading standards, processes, and mandates to ensure all residents receive quality food and good nutrition care. From the Fellowship learnings, the Fellow has made a series of practical proven to work recommendations for RACF organisations, and Government. These recommendations must be implemented to improve the equity of care older adults receive in Australia. All older adults deserve to receive high quality nutrition care to improve their health and overall quality of life.

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