

## **1. INTRODUCTION AND BACKGROUND**

In 1993, a specialist dietitian-nutritionist from the (then) Health Promotions Unit for Adults with Developmental Disabilities<sup>1</sup> conducted a survey of the nature and causes of underweight status amongst people with multiple disabilities residing in state institutions (“the Underweight Report”).<sup>2</sup> The survey aimed to identify factors contributing to underweight status of residents, and strategies for dealing with or removing such factors. The findings of the survey confirmed that underweight and undernourishment are significant problems within residential centres and that there are policy and practice improvements which can be made to reduce the risks of such factors for people with multiple and significant disabilities.

The Community Services Commission reviewed this report, together with associated publications in late 1995.<sup>3</sup> We had also gathered information from other sources, raising concerns about the adequacy of nutritional and mealtime practices in residential services. Information sources included our own reviews of people with disabilities in care, reports from Community Visitors, complaints and enquiries.

The commission determined that this issue required ongoing monitoring for the following reasons:

- the serious and potentially life threatening risks faced by people with multiple disabilities in being poorly nourished and chronically underweight
- the high level of dependency of such people on their carers and their associated inability to redress such a situation themselves or to bring it to the attention of others; and
- the systemic nature of the issues raised in the Underweight Report.

This report outlines the patterns identified in our monitoring and highlights the outstanding issues to be addressed. While most of the information we have gathered relates to practices in government centres, it is clear that this is an issue which affects all people with significant disabilities in residential care. We have proposed some recommendations for addressing the risks of malnutrition and underweight status faced by people with multiple disabilities.

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<sup>1</sup> A specialist unit of the Department of Community Services, located at Royal North Shore Hospital, since closed due to lack of government support

<sup>2</sup> Report on the Problem of Underweight in Residential Centres for the Developmentally Disabled, Lynette Stewart, 1993

<sup>3</sup> “Nourished Or Undernourished ? A Nutrition Survey of Underweight Residents in NSW Residential Centres” paper presented by Lynette Stewart at ASSID Conference December 1993; “Project Renourish: A Dietary Intervention to Improve Nutritional Status in People with Multiple Disabilities” Lynette Stewart, ANZJDD 1995

The recent report from the Western Sydney Intellectual Disability Support Group (the 'Support Group') of the findings of their "Nutrition Project" repeats and builds on some of the themes raised by the Underweight Report in 1993.<sup>4</sup> The commission applauds this initiative of a local parent based support group, and supports the recommendations they have made, both for local level improvements and to the Department of Community Services.

At a time when the Minister and the Department of Community Services is considering the findings and recommendations of the "Nutrition Project", we suggest that the response should be a comprehensive and systematic one, which minimises the risks of malnourishment and underweight status faced by people with developmental disabilities, across all residential settings. The broader information gathered by the commission, and outlined in this report, demonstrates the need for such a response.

## **2. METHODOLOGY**

This report outlines our analysis of information gathered from a range of different sources, over a period of 2 years. Some of this information (such as the reports from individual centres about their nutritional and mealtime practices) has not been independently verified by the commission, although some aspects of the information have been compared to information which has been gathered through other sources.

The objectives of the commission's activity in this area included:

- to assess the existing policy and service provision framework to protect the health of people with disabilities who may be at risk of malnourishment or underweight status;
- to assess the extent to which the findings and recommendations of the 1993 Underweight Report are being addressed;
- identify existing gaps in policies, practices and services which may place or leave people at risk of malnourishment or underweight status; and
- to make recommendations to address these gaps.

The approach used by the commission in meeting these objectives has included the following:

- review and analysis of the following reports and papers: Underweight Report (Stewart, 1993), "Nourished or Undernourished" (Stewart 1993); "Project Renourish" (Beange, Stewart and Gale, 1995); and "The Nutrition Project" (Hunwick and Dear, 1997);
- request for information from Department of Community Services in relation to nutrition and mealtime practices in its 8 large residential centres, based on issues and recommendations from the Underweight Report (copy of letter requesting information is attached at Appendix 1);

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<sup>4</sup> "The Nutrition Project - a case study for screening, assessment and intervention" undertaken by the Western Sydney Intellectual Disability Support Group, in liaison with the WSDDS, with funding from the Department of Community Services

- analysis of information provided by 7 individual residential centres against the issues and recommendations from the Underweight Report<sup>5</sup> (profile information of these centres is attached at Appendix 2);
- inclusion of Nutrition, Hygiene and Health Care as one of the key practice areas reviewed in the Performance Audit of large residential centres ('Performance Audit') conducted jointly by the NSW Audit Office and the Community Services Commission in 1996/97, and gathering of information accordingly; and
- reviewing information about nutrition and mealtimes practices, gathered by Community Visitors to selected large residential centres, in response to a request by the commission.

The information provided by individual centres in response to our initial request for information was often not specific enough to enable us to determine whether issues raised in the Underweight Report were being addressed. Our analysis of the information provided by centres identified gaps and discrepancies in their responses, in the light of the Underweight Report. However, the aim of our monitoring was to identify gaps in the current system of policy and practice, rather than make conclusive findings about the practices in individual centres or in relation to individual residents. On this basis, we did not pursue further information from individual centres, but reviewed their information in light of data gathered during the Performance Audit (where applicable) and Community Visitors.

The Department of Community Services also provided the commission with an update of 'Action Since Report Submitted by Ms Lyn Stewart' and the response on WSDDS following the Nutrition Report<sup>6</sup>, on 31 October 1997. The information provided in these documents has been taken into account in this report.

The report which follows discusses the main findings and themes from the information reviewed across all centres. The detailed analysis of the information is found in appendix 3.

### **3. SCOPE AND NATURE OF THE PROBLEM**

While figures vary as to the extent of underweight status in the population of people with significant disabilities, recent local research provides enough evidence to confirm that it is an issue warranting systematic attention. Findings from within NSW government large residential centres in the past 5 years include:

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<sup>5</sup> Information was provided by Grosvenor Centre, Hunter Region Developmental Disability Services, Lachlan Centre, Peat Island Centre, Riverside Centre, Strathallen Centre and Western Sydney Developmental Disability Services. Information was also supplied by the Woodstock Centre, but has not been included in this analysis as its operations are more aligned to group home practices

<sup>6</sup> Document titled 'Recommendations of the Nutrition Report'

- approximately 15% of people with developmental disabilities are underweight, which is approximately double the percentage for the general Australian population.<sup>7</sup>
- in one large residential centre 82 children and adults of 131 residents (62%) were identified as underweight, through either BMI measurements<sup>8</sup> or visual assessment<sup>9</sup>
- in another large residential centre 12.6% of residents from a population of over 400 were assessed as having a BMI indicating severe nutritional depletion.<sup>10</sup>

Stewart has identified a number of factors which contribute to the insufficient energy intake of underweight residents in institutions. These factors include:

a) Low food intake due to:

- dependency for feeding,
- lack of appetite (caused by side effects of medication, lack of exercise, inappropriate posture, meals following too quickly after one another, constipation, chronic underfeeding or reflux)
- chewing and swallowing problems,
- inability to ask for more,
- insufficient time allowed for meals
- low nutrient density and/or palatability of meals

b) Staff inability to identify or quantify the problem<sup>11</sup>

The consultant dietitians who conducted the Nutrition Project reported that there is extensive literature confirming the increased risks of malnutrition faced by people with significant disabilities. They identified the following specific aspects to this risk:

- “people with multiple disabilities are at high risk of malnutrition
- death due to respiratory disease is the major risk
- swallowing is often unsafe resulting in food aspiration (sometimes silent) and recurrent chest infections and aspiration pneumonia;”<sup>12</sup>

If the risks of undernourishment are not properly managed, people with significant disabilities are likely to enter a vicious circle of malnutrition and its effects. Hunwick and Dear note that the consequences of malnutrition include impairment of the immune system (resulting in more frequent and serious infections), muscle and nerve weakness, depressions, irritability and confusion, lethargy, drowsiness and feeding difficulties. These can make feeding of people

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<sup>7</sup> pg 17

<sup>8</sup> Body Mass Index (BMI) is a measurement which allows comparison with the general population. It is calculated as  $BMI = \text{weight}/\text{height}^2$

<sup>9</sup> Project Renourish

<sup>10</sup> The Nutrition Project

<sup>11</sup> The Underweight Report

<sup>12</sup> Report of The Nutrition Project, pg 4

with significant disabilities even more difficult than under 'normal' circumstances.<sup>13</sup>

The impact of malnutrition can also become life threatening where the consequent reduction in muscle strength leads to silent aspiration of food (as the person loses the ability to gag and cough) and reduced ability to fight any subsequent respiratory infection (due to impaired immune systems).<sup>14</sup> For people whose disabilities mean that they experience difficulties in swallowing (dysphagia), this risk is even greater:

"Dysphagia is the greatest risk factor for aspiration of food into the lungs. When this occurs, infection and possible death due to aspiration pneumonia becomes significant. The discomfort occurring as a result of food 'going down the wrong way' when eating, usually means that the individual is less comfortable eating and begins to refuse food, leading to a reduction in food intake."<sup>15</sup>

Of the deaths of people with a disability in care reported to the commission over the past 3 years (103 total<sup>16</sup>), 41 individuals are reported to have died from a respiratory illness such as bronchopneumonia. Of these, 5 individuals are reported to have died specifically of aspiration pneumonia. A further 2 people died after choking on food. Information on cause of death provided to the commission varies, but includes coronial findings, autopsy reports and death certificates. In some cases, the report to the commission does not include a final finding on cause of death, and we have relied on preliminary information as provided by DOCS. While the information available to the commission is not sufficient to identify which of the deaths from respiratory illnesses are related to malnutrition or dysphagia, the figures highlight the need for high levels of care and attention to such issues for people with significant disabilities.

The dietitians involved in the above projects all stressed that while there was a very high risk of malnourishment in the populations of people with significant disabilities, these risks could be managed: "malnutrition is preventable in this population."<sup>17</sup> Stewart notes that "many of the factors influencing the low weight status of underweight residents are factors open to modification and amelioration."<sup>18</sup>

Two recent, independent projects to provide additional nourishment to residents of in large residential centres have provided evidence of positive outcomes of appropriate intervention. In Project Renourish (undertaken at Hunter Region

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<sup>13</sup> Report of The Nutrition Project, 1997

<sup>14</sup> The Underweight Report, pgs 4-5

<sup>15</sup> The Underweight Report, pg 20

<sup>16</sup> These are predominantly people who were in the care of the Department of Community Services, as there is an arrangement between the department and the commission for reporting of such deaths. However, these figures also include five deaths of people in non-government care, all of whom died from bronchopneumonia

<sup>17</sup> Report of The Nutrition Project, pg 4

<sup>18</sup> "Nourished or Undernourished?"

Developmental Disability Service in 1992-93) underweight residents were provided with an enriched diet, as a global strategy, and documented significant improvements in the nutritional and biochemical status of those residents after 12 months. The Nutrition Project (undertaken at Western Sydney Developmental Disability Service in 1997) showed some significant weight gain for two residents who were underweight and malnourished, within 3 months of assessment and individualised intervention.<sup>19</sup>

The fact that the significant risks associated with malnutrition and underweight status can and have been, managed in at least two large residential centres points to the potential for ensuring that all people with significant disabilities are similarly protected from such risks. While the initiatives and outcomes at Hunter Region Developmental Disability Service (HRDDS) and Western Sydney Developmental Disability Service (WSDDS) are commendable, there is a need for a systematic, statewide policy and practice response to the nutritional needs of people with multiple disabilities. Without such a systematic response, the well-being of people in care will be dependent upon the individual decisions of service providers, with resultant inequities in access to basic health protection.

Service providers (and through them, the government) have a legal duty of care to protect people in residential care from foreseeable harm. This includes harm experienced as a result of poor nutrition. In a number of areas, the failure to address nutritional needs has been labelled as a form of abuse<sup>20</sup> or neglect,<sup>21</sup> and it has been argued that for people with disabilities in residential care, it “would justify a label of nutritional abuse, failure to provide basic requirements to residents, withholding of services, or even systemic abuse.”<sup>22</sup> Given the research which highlights both the risks of malnutrition faced by people with significant disabilities, and the strategies for managing such risks, the failure to address these issues leaves service providers and the government exposed to legal action for damages.

#### **4. CURRENT POLICY AND PRACTICE FRAMEWORK**

The Underweight Report noted that the only resource available to large residential services was a Food Services Manual for Fifth Schedule Hospitals,<sup>23</sup> developed by the Department of Health, which was responsible for residential centres accommodating people with developmental disabilities up to 1989. Other than centres which chose to continue referring to the Food Services Manual, the

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<sup>19</sup> See case Study 1 and 3

<sup>20</sup> In the child protection area, ‘non-organic failure to thrive’ is used to describe infants and children whose growth and development is significantly below age-related norms and where treatment involves adequate feeding. It has been described as the meeting point of emotional abuse and neglect.

<sup>21</sup> Malnutrition is classified as a type of neglect in relation to elder abuse - see “Abuse and Adults with Intellectual Disability Living in Residential Services” by Conway et al, 1996, pg 31

<sup>22</sup> As above, pg 31

<sup>23</sup> Food Services are a unit within Fifth Schedule Hospitals responsible for the planning and preparation of meals on-site for residents

development of any other standards, policies and procedures in relation to nutrition and food services is “left up to the individual centres since the Department of Community Services took over the developmental disability residential services”.<sup>24</sup>

In our original request for information to the department, we asked for copies of any “policies, guidelines or standards” in relation to nutrition and mealtime practices. The department did not provide any corporate policy in response to this request, and only 3 centres provided any documents which could meet the above description.

Two of these documents appeared to apply across the department, but were only provided by one centre (WSDDS). These were:

- Directors Memo, Department of Community Services, issued July 1991, specifying that mealtimes in large residential centres shall not be earlier than 7am, 12 noon and 6pm (6.30 daylight saving); and
- copy of Food Services Standards (undated), dealing with menu planning, and food choices.

The third document was a policy on “Management of Eating and Drinking Disorders” developed locally by HRDDS, dated Oct 1994.

The department has since issued its Policies for Working with People with Disabilities, which includes a policy titled Healthy Lifestyles.<sup>25</sup> While this policy includes a section on ‘diet’ issues, it is limited by the following:

- the policy is geared towards residents’ exercise of choice, and doesn’t deal with issues for those people who are unable to exercise choice (eg. in large residential centres) or who require significant support;
- a diagram titled “Nutrition Decision Tree” is included in the appendix, but this is not referred to in the body of the policy, and it is not clear what staff are meant to use it for, or who is responsible for nutrition decisions;
- there is no reference to risk indicators, or weight monitoring requirements.

The commission notes that the Ageing and Disability Department are in the process of developing a manual of “Policies and Practical Guidelines for Service Providers to Assist with Conformity to the Disability Services Act (NSW) 1993”. The draft of this manual contains a section on Policies and Practices for Nutrition, Health and Hygiene, but like the DOCS policy, contains only very brief guidelines regarding diet.<sup>26</sup>

It appears that there are no policies or guidelines to ensure that residential services establish and use appropriate practices in nutrition, weight monitoring, and mealtime practices, nor an overarching framework to ensure that the nutritional needs of people with significant disabilities are appropriately considered and met.

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<sup>24</sup> The Underweight Report, pg 17

<sup>25</sup> Policy 6.15, Version 2, October 1996

<sup>26</sup> Draft manual provided to commission July 1997



## **5. FINDINGS IN TEN KEY AREAS EXAMINED**

Whereas the Underweight Report had made recommendations in relation to specific centres, the commission wanted to establish that the issues identified in the Underweight Report were being dealt with across all centres. As a result, we examined the following key areas of concern identified from our review of the Underweight Report.

### **5.1 Provision of hot breakfasts**

Stewart notes in the Underweight Report that the Dietitians' Association of Australia (NSW Branch) believes that "the continental breakfast disadvantages the undernourished patient"<sup>27</sup> and recommended that hot breakfasts be included in specific units.

Information provided by individual centres indicates that 4 of the 7 centres provided hot breakfasts at least once a week. One service has since changed to continental breakfasts, but states that underweight residents will be "targeted for hot breakfasts."

There was no indication in the information provided by the centres that decisions regarding the provision of hot or continental breakfasts are made for nutritional reasons, rather than operational ones (such as cost or staffing patterns).

### **5.2 Mealtime schedules**

The Underweight Report recommends 5 hours between meals and no more than 13 hours between supper and breakfast.

Existing guidelines for mealtime schedules are:

- Food Services Manual for Fifth Schedule Hospitals which recommends meals be served between 7-8.30am; 12-1.30pm; 4.45-5.30pm
- Directors Memo (1991) which recommends meals not be served before 7am, 12 noon, and 6-6.30pm

Information provided by individual centres showed that mealtimes varied as follows:

- Breakfast ranges between 6.30am and 9am, lunch between 12pm and 1pm; dinner between 4.45pm and 6pm
- Not all services indicated that supper was provided
- In some cases, the period between meals is as little as 3.45 hours (eg between lunch and dinner) and up to 16 hours between dinner and breakfast where no supper is provided.

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<sup>27</sup> Stewart 1993, pg 13

There is evidence from the Performance Audit<sup>28</sup> to indicate that mealtime schedules are heavily influenced by staffing issues, to the detriment of good nutritional practice. For example, at one service, the audit team found that "Recently directions were issued to staff to ensure that dinner was not eaten before 5pm. Dinner times driven by the finishing times of Hospital Assistants." Similarly, another centre informed the audit that "Time available for the evening meal may be driven by the general service (domestic) roster."

### **5.3 Identification of and response to underweight residents**

The Underweight Report noted that a contributing factor to chronic underweight status in people with significant disabilities was the inability of services to quantify the problem. The survey found that while all centres weighed clients regularly, this information was generally not considered against benchmarks such as height or target weights.

These findings are consistent with the information provided by the centres in 1995, and the findings of the Performance Audit in 1996. Only 2 of the 7 centres who provided information to the commission reported using a Body Mass Index ('BMI') measurement to determine the weight status of residents. Of these, one centre felt that "the measurement of their height may not be very accurate because the majority of them have severe spasticity and contractures".<sup>29</sup> In the Underweight Report, this factor had been dealt with by measuring the total distance from the back of the head to the heel then reducing that length by 8% to gain an estimated height measurement. There is no indication that this method had been discussed or adopted as an approach to calculating BMIs of residents unable to stand or lie straight in any other centres.

Information from centres themselves, the Performance Audit and Community Visitors confirmed that there is wide variation in weight monitoring practices across centres. These ranged from one service which measures height and weight of residents monthly and conducts BMI surveys for the entire resident population every 6 months,<sup>30</sup> through to one centre which reported that weight monitoring was conducted only through annual medicals and for the purpose of calculating medication dosages.<sup>31</sup>

Most centres rely on staff observation and monthly weight monitoring to identify whether residents are underweight.

Options for responding to residents who are identified as underweight also varied. These options ranged from weight results being provided automatically to a dietitian, to referral to medical officers, and attempts to obtain advice through generic services.

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<sup>28</sup> Performance Audit Report of Large Residential Centres for People with a Disability, NSW Audit Office and the Community Services Commission, 1997

<sup>29</sup> WSDDS

<sup>30</sup> HRDDS

<sup>31</sup> Riverside

The findings of the Performance Audit reflected the variations in weight monitoring systems reported by services. However, the audit also found that existing weight monitoring systems were not effective:

“all centres had established systems for monitoring the health of residents such as weight...recording and monitoring of this information did not always lead to timely intervention. For example, weight losses of up to 6 kgs in a month were not investigated by one centre.”<sup>32</sup>

#### **5.4 Individual assessments and nutrition plans**

Another project undertaken by Ms Stewart, Project Renourish, demonstrated the benefits of general dietary intervention with a population of residents with very high physical support needs and significantly underweight (ie BMI of less than 20).<sup>33</sup> Ms Stewart concluded from this project that although “even limited interventions are beneficial”, clearly

“more can be achieved in improving nutritional status if interventions are designed on an individual basis. Assessment of eating and swallowing problems and the development of feeding and dietary programmes should be by a multi-disciplinary team which includes a dietitian, a medical practitioner, a nurse and a speech pathologist.”<sup>34</sup>

The importance of individual assessments and intervention plans was also emphasised in the Underweight Report:

“In relation to the feeding requirements of underweight clients it is recommended that nutritional assessment, individual feeding programs and monitoring be conducted by an on-site dietitian. A multi-disciplinary approach to the assessment of feeding problems is highly desirable.”<sup>35</sup>

The commission sought information from the centres as to the number and proportion of residents who had nutritional assessments in the past twelve months, resulting in the development of individual nutrition or diet plans. The responses demonstrated a wide variation in the extent to which services provided residents with access to such assessments.

In one centre 165 residents had been individually assessed for their nutritional needs,<sup>36</sup> while in another, only one resident had an individual assessment (relating to a diabetic diet).<sup>37</sup> The Riverside Centre noted that a number of residents had been assessed as part of the survey undertaken by Lynette Stewart

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<sup>32</sup> Performance Audit Report, pg 47

<sup>33</sup> See “Project Renourish: A Dietary intervention to Improve Nutritional Status in People with Multiple Disabilities” ANZJDD

<sup>34</sup> See “Project Renourish: A Dietary intervention to Improve Nutritional Status in People with Multiple Disabilities” ANZJDD

<sup>35</sup> pg 18

<sup>36</sup> HRDDS

<sup>37</sup> Strathallen

in 1993 (reported in the Underweight Report), and had been on supplementary feeding programmes since that time. However there had been no other reviews of the nutritional needs of residents since then.

WSDDS stated that 30 residents of the Rydalmere Centre had been identified as under-nourished during 1995. Following 'routine blood tests' on these residents, 12 were referred to the gastroenterology clinic and 1 to the dietitian at Westmead Hospital. From the Marsden Centre, 9 residents were identified as underweight and 7 of these seen for a nutritional assessment. In contrast to this, when the Nutrition Risk Screening Tool<sup>38</sup> was administered across all residents of Rydalmere and Marsden, as part of the Nutrition Project in 1997, a total of 54 residents were identified as either underweight (36), or severely underweight (18). This discrepancy highlights the importance of systematic screening of residents at risk of malnutrition.

The information provided by these centres was consistent with later findings of the Performance Audit, which indicated that, other than the HRDDS, no centres had direct access to a dietitian and that there was a reliance on Medical Officers in dealing with underweight issues and making decisions on dietary supplements.

Only one residential centre indicated that a multi-disciplinary approach was used when considering the nutritional needs of residents with significant disabilities. The HRDDS established a multi-disciplinary team of dietitians, speech pathologists, occupational therapists, physiotherapists, medical and nursing staff in mid 1994. The service reported that the role of this team is to systematically assess all residents for eating and drinking difficulties, and develop strategies for those residents with eating and drinking disorders.<sup>39</sup> DOCS also report that this service is trialing a nutrition screening tool, with the aim of being able to more quickly identify residents with nutrition problems.<sup>40</sup>

The Nutrition Project recognised the importance of a multi-disciplinary approach, by ensuring that a speech pathologist conducted assessments and made recommendations about the swallowing ability and safety of those individuals identified at risk of malnutrition. This was necessary to ensure that any subsequent nutritional planning was undertaken "in the knowledge that such feeding would not endanger the client by increasing the risk of aspiration into the lungs."<sup>41</sup>

The project consultants noted that a common problem in addressing the needs of vulnerable residents was the "lack of organisational support to sustain a multi-disciplinary approach."<sup>42</sup> As a result, the project recommended to the

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<sup>38</sup> A questionnaire developed by the consultant dietitians for this project, designed to identify individuals who may be at risk of nutrition abnormalities

<sup>39</sup> Response to commission's request for information, from HRDDS, February 1996

<sup>40</sup> 'Action Since Report Submitted by Ms Lyn Stewart'

<sup>41</sup> The Nutrition Project, pg 16

<sup>42</sup> Ibid, pg 18

Department of Community Services that “all clients ... have an interdisciplinary feeding assessment at frequent intervals”<sup>43</sup> and that WSDDS establish a “multi-disciplinary team for treating clients with feeding difficulties.”<sup>44</sup> The commission notes that WSDDS has already taken steps to provide a speech pathologist and a specialist dietitian for the recommended multidisciplinary team.<sup>45</sup> While this is a positive response from WSDDS, the issues and needs identified in the Nutrition Project are unlikely to be unique to this service, and a more systematic response is required across the state.

## **5.5 Provision of nutritional and dietetic advice**

The Underweight Report notes that “among the severe and profoundly handicapped there are many dietary problems related to their ability to take a normal diet. These problems call for dietetic advice in their management.”<sup>46</sup> The commission sought information from the Department of Community Services about arrangements for the provision of dietetic and nutritional advice for residents of institutions.

The response from the department stated that “professional advice on diet/nutrition matters is provided by on-site specialists or local health services, and all services indicated no difficulty in obtaining such advice.”<sup>47</sup>

Responses from the individual centres indicated a wide disparity of arrangements. Four centres relied entirely on generic services through local public hospitals.<sup>48</sup> However, in contrast to the assertion of the department, 2 of these centres reported that they are not able to access needed services from these sources:

“Specialist nutritional advice has been difficult to access. From past experience approaches to nutritionists employed by the Health Department have been unable to supply our clients with advice... Consumers are reliant on staff to access information (regarding nutrition) from whatever sources are available.”<sup>49</sup>

“Access to specialist dietitian services through Westmead Hospital has been stopped, due to resource issues at Westmead.”<sup>50</sup>

Information provided from independent sources also indicates that generic services are not meeting the needs of residents in institutions. For example, the Nutrition and Dietetic Adviser of the Mid Western Health Service has stated that “we do not currently provide the services of any dietitians to the Riverside

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<sup>43</sup> The Nutrition Project, Recommendation 1

<sup>44</sup> Ibid, Recommendation 3

<sup>45</sup> WSIDSG Newsletter, September 1997

<sup>46</sup> pg 17

<sup>47</sup> Letter from Department of Community Services to commission, dated 25.3.96

<sup>48</sup> Riverside, Strathallen, Peat Island, and WSDDS

<sup>49</sup> Peat Island

<sup>50</sup> WSDDS

Centre. The Riverside Centre does, however obtain part of its food service from Orange Base Hospital and has the ability to request special diets from the Diet Cook based at Orange Base Hospital.”<sup>51</sup>

It is questionable that even if residents were seen by dietitians and nutritionists through the local public hospital system, whether this would be sufficient. The Underweight Report notes that

“the advice possible from an out-patient dietetic clinic is very likely to be inadequate because of insufficient information to make a full assessment...because of the clients inability to relate information, it is often necessary to make meal time observations to understand the nature of the problem.”<sup>52</sup>

This view has been supported by the Dietetics Department of Westmead Hospital and Community Health Services, following a review of the Underweight Report, stating that “it is of great concern...that we would not be able to adequately address these problems in an outpatients situation”.<sup>53</sup>

Only two centres had made arrangements for direct provision of dietetic and nutritional advice. The HRDDS employs two part-time dietitians, and set up a multi-disciplinary team to assess feeding difficulties and design individual interventions.<sup>54</sup> The Grosvenor Centre advised the commission that it arranges for an annual review of Food Services and residents by a paediatric dietitian.<sup>55</sup>

The joint Performance Audit also found that

“while all centres accommodate people who are physically or medically frail (and therefore vulnerable to being underweight), access to specialist dietary advice for individual residents or to assist with menu planning is limited. While one government centre employs its own dietitian (HRDDS), others rely on public hospital services if a nutritional assessment is required. Centres report varying levels of accessibility to generic services.”<sup>56</sup>

The need for regular nutritional and dietetic advice is confirmed by a nutrition intake analysis of 3 day food records for residents at WSDDS. The analysis of individual food intake records highlighted the following issues:

- nourishment levels between meals was low
- dietary supplements were sometimes misused
- energy intakes were low for some clients

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<sup>51</sup> Letter from Mid Western Health Service, dated 2.10.96

<sup>52</sup> pgs 17-18

<sup>53</sup> Letter from Deputy Chief Dietitian, dated 29.3.94

<sup>54</sup> Team known as Gagbusters

<sup>55</sup> The commission has also been advised that Peat Island has contracted the services of an independent dietitian to provide “advice and training to the kitchen and nursing staff regarding the specific requirements of residents at the Centre.” This advice was provided in response to a preliminary investigation report where issue of mealtime supervision and the quality and quantity of food provided (C95/1188)

<sup>56</sup> Performance Audit Report, pg 47

- low nutrient density of food was an issue
- total volume of intake was low for those people who had difficulty feeding.<sup>57</sup>

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<sup>57</sup> The Nutrition Project, pg 16

The dietetic consultants for the Nutrition Project noted that:

“A poor level of nutrition knowledge is compounded by the lack of knowledge of the specific nutrition needs of people with multiple disabilities... In some cases staff told the Consultant Dietitians that they have already ‘tried everything for this client without success’. They genuinely have tried everything that they know, but there are other nutritional options that they are not aware of which would be more appropriate.”<sup>58</sup>

The consultants worked closely with the staff at WSDDS during the Nutrition Project, and both the dietitians and the speech pathologist noted that staff were aware of the difficulties they faced, and anxious to gain information which would assist them to better provide for the nutritional needs of residents. The consultants reported that all staff had stated a desire to be able to access nutritional and dietetic advice.

DOCS reports that since the Nutrition Project, WSDDS has allocated funds to contract the services of a dietitian (1 FTE) and additional speech pathologist support.<sup>59</sup> While it is encouraging that such support will shortly be available at WSDDS, there is still an absence of a systematic approach across government centres to ensure access to needed expertise.

#### **5.6 Staffing ratios at mealtimes in units with people of high physical dependency**

Residents with high physical support needs require particular attention and assistance from staff at mealtimes to ensure they are able to eat as much food as they need. The Underweight Report notes that “high client/staff ratios at mealtimes reduce the ability of staff to spend as much time as is needed feeding some more needy clients.”<sup>60</sup> A review of client staff ratios conducted as part of the Underweight report found that

“Stockton Units 19 and 20 and Marsden Units 1 and 2 have the least number of staff for hand feeding of dependent clients. Nurse may be responsible for hand feeding 6 to 8 fully dependent clients at a mealtime.”<sup>61</sup>

The commission sought information about any policy for determining staffing ratios, and the actual staffing ratios in those units where residents have the highest level of dependency.

There is no policy or formula for determining staffing allocations to centres, with the result that residential centres are funded on historic grant levels, without

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<sup>58</sup> Ibid, pg 21

<sup>59</sup> ‘Action Since Report Submitted by Ms Lyn Stewart’ and ‘Recommendations of Nutrition Report’

<sup>60</sup> pg 5

<sup>61</sup> pg 10

regard to equity or residents' needs.<sup>62</sup> Decisions about allocation of staff to units within centres is at the discretion of centre management.

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<sup>62</sup> See Performance Audit Report: Large Residential Centres for People with a Disability in NSW, pg 70

Responses from the individual centres included:

- Grosvenor - no clear answer on Units 1 and 2 other than saying that supervisor available during mealtimes
- Riverside (Unit 8, Narran) - 1:2.5
- Marsden Centre (U1 and 2) range from 1:4 to 1: 6.2.
- Stockton (Units 19 and 20) ranged from 1:4 to 1: 7:2
- Strathallen (Kambala) 1:4.5 to 1:9
- Lachlan Centre range from 1:2.5 to 1:6
- Peat Island 1:6

The lowest ratios quoted mean that there could be one nurse responsible for up to 9 residents who may need assistance with eating. The best ratios quoted mean that one nurse is available for 2.5 residents.

A few centres noted that staffing during mealtimes was an issue. One centre reported that although the "full disposition of deployed staff are on duty during resident meal times... Additional staff establishment strongly desired."<sup>63</sup> Another centre noted that "frequent understaffing does not enhance the consumers meal periods."<sup>64</sup>

WSDDS also noted that "shift changeover at 6.30pm at Rydalmere Centre, because of the shift patterns worked there. This disrupts mealtimes for residents."

During the audit, it was noted that staff breaks often occur around the same time as resident meals, so even though the roster may indicate that there are (say) three staff on duty, only two may actually be available for residents.

The issue of staff supervision and support for mealtimes was also canvassed in an investigation conducted by the commission following a complaint about Peat Island in 1996. The commission concluded that there was "lack of monitoring of staff by management at mealtimes, and conflicting information provided by staff [about adequacy of staff support for residents at mealtimes]."<sup>65</sup>

Information from Community Visitors also indicates that in at least 3 centres, staff meal breaks do occur at the same time as resident meal times, effectively lowering the number of staff available to assist with feeding of residents.<sup>66</sup> One Community Visitor also observed that "meals go cold as they are left on a trolley while feeding one client then another."<sup>67</sup>

A problem created if staff changeovers or breaks coincide with resident mealtimes is that staff may not be able to adequately observe the intake of

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<sup>63</sup> Riverside

<sup>64</sup> Peat Island

<sup>65</sup> C95/1188

<sup>66</sup> HRDDS, Riverside and Strathallen

<sup>67</sup> Stockton Centre, HRDDS

residents throughout their meal. Staff may not know for example whether an empty plate at the end of the meal means it was consumed or spilled earlier. In conducting assessments of residents as part of the Nutrition Project, the speech pathologist noted that

“In some units the ratio of dependent eaters to people assisting was unworkably high. That is, it was simply not possible in a number of cases for staff to allow enough time to assist clients with high support needs in eating and drinking at the highest standard of safety.”<sup>68</sup>

The speech pathologist observed that this led to clients being fed too rapidly or in incorrect positions, significantly increasing the risk of aspiration. She recommends that staff ratios to dependent clients be reviewed.

### **5.7 Arrangements to ensure adequate time for meals**

A factor related to staffing ratios at mealtimes is the importance of ensuring an adequate period of time for the feeding of residents who are highly dependent. Stewart notes that “clients may become distressed when feeding is attempted at too great a speed.”<sup>69</sup>

The commission sought information from individual centres about arrangements they have established to ensure that adequate time is provided for meals. The responses ranged as follows:

- 3 services provided no information in response to this question<sup>70</sup>
- Other responses simply state that there is no rushing, and no set periods for meals times<sup>71</sup>
- HRDDS stated that mealtimes are extended in Units 19 and 20
- WSDDS says that one hour is scheduled for meals but also noted that “there is a shift changeover at 6.30pm at Rydalmer...this disrupts meal times for residents.”

Although the department stated that “mealtimes are never rushed and are flexible depending on the needs and wishes of the residents”,<sup>72</sup> the Performance Audit found that mealtimes were heavily influenced by staff and roster issues. For example, the audit team found that at Strathallen “dinner times are driven by the finishing time of Hospital Assistants”. In WSDDS, the audit team found that “mealtimes are generally a maximum of 15-20 minutes per sitting, especially at Marsden where the dining rooms are too small to allow all residents to eat at the same time.” In its response to the audit findings, WSDDS reported that “the time available for the evening meal may be driven by the general service (domestic) roster.”

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<sup>68</sup> Report from Speech Pathologist, appendix to The Nutrition Project

<sup>69</sup> pg 5

<sup>70</sup> Lachlan Centre, Peat Island and Grosvenor Centre

<sup>71</sup> Strathallen and Riverside

<sup>72</sup> Letter from DOCS dated 25.3.96

Overall, the joint Performance Audit found that “meals are provided on a fixed schedule with limited time to eat.”<sup>73</sup>

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<sup>73</sup> Performance Audit Report, pg 46

## **5.8 Training for staff in nutrition, diet and identification of underweight indicators**

The commission sought information from the department regarding the training provided to staff of large residential centres in nutrition and identification of weight status. Our concerns regarding the adequacy of staff training in this area arose from findings in the Underweight Report that

“Low weight is often perceived by staff as a natural concomitant of their specific developmental disability...there is often a perception amongst staff that these clients are incapable of gaining weight. Staff training on the matter of nutritional requirements and dietary adequacy is obviously not addressing the subject effectively.”<sup>74</sup>

The department noted in its response that “all nursing staff receive training in nutrition as part of their certificate training. Other training is generally provided on an Area by Area basis. It is clear that the consistency of training is an issue that requires further consideration.”<sup>75</sup>

Responses from the individual centres varied from:

- One service (HRDDS) which provided in-service training to graduate nurses on “Assessment and Nutritional Maintenance for People with Severe Physical Handicaps”, as part of its orientation program, as well as unit and client specific training as required;
- Another centre providing inservice sessions for staff of identified units;
- Two centres stating that no specific training was provided to staff (Strathallen and Grosvenor);
- Reliance on enrolled or registered nurse training to provide the needed knowledge and skills in nutrition issues.

A number of responses noted that there was a need for further staff training and guidance in this area:

“There is no current policy for nutrition or recent formal training programs (except for a training course provided by Bidura - Healthy Lifestyles, has not been held in the Area since 1994), available for staff.”<sup>76</sup>

“Approaches are being made to staff development with respect to the conduct of refresher inservices on this issue.”<sup>77</sup>

“No specific training is offered to the staff of Strathallen Centre in nutrition matters.”<sup>78</sup>

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<sup>74</sup> pg 6

<sup>75</sup> Letter from DOCS 25.3.96

<sup>76</sup> Grosvenor Centre

<sup>77</sup> Riverside Centre

<sup>78</sup> Strathallen Centre

DOCS has advised that some services are arranging inservice training independently, through consultant dietitians (eg Grosvenor).<sup>79</sup> While understandable (and commendable) that individual centres are initiating such training, it highlights the lack of systematic and consistent response to the training and knowledge needs of staff working with people with significant disabilities.

A speech therapy assessment of thirteen residents as part of the Nutrition Project at WSDDS also highlighted the need for specific training for staff. Although all direct care staff at WSDDS are registered or enrolled nurses, staff awareness and training was identified by the speech pathologist as a significant safety issue.

“...there was evidence of a lack of specific education among direct care staff of some safety issues. Specific - and extremely important - examples include:

- lack of knowledge of appropriate head and neck positioning to maintain closure of trachea (wind pipe)
- some confusion in some direct care staff of safety procedures for CPR (cardio-pulmonary resuscitation) and incidents of severe aspiration and/or choking.

**The lack of information about appropriate positioning of the head and neck and the confusion of CPR techniques with techniques for dealing with choking incidents could lead to immediate and ongoing danger for clients.**<sup>80</sup> (emphasis in original)

The speech pathologist recommends that all direct care staff undertake education and training in dysphasia management as an essential requirement.

Community Visitors reported a range of strategies used by services to ensure staff were aware of specific feeding techniques for individual residents. These strategies included whiteboards or information charts listing instructions for feeding techniques for individual residents, and on the job training from senior or more experienced staff. DOCS also report that in HRDDS, an individualised ‘feeding programme summary’ is placed in the unit to guide the action of direct care staff, following a multi-disciplinary assessment and management plan.<sup>81</sup>

While such strategies may be appropriate for ensuring that individual feeding techniques are followed, there is still a need to ensure that all staff have up-to-date competencies in feeding and mealtime practices and an understanding of nutrition issues as they affect people with significant disabilities.

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<sup>79</sup> ‘Action Since Report Submitted by Ms Lyn Stewart’

<sup>80</sup> Speech Pathologists Report, appendix to the Nutrition Project

<sup>81</sup> ‘Action Since Report Submitted by Ms Lyn Stewart’

## **5.9 How to compensate for the fact that residents may not be able to indicate hunger**

One of the factors identified in the Underweight Report as contributing to insufficient energy intake in people with significant disabilities is their inability to indicate when they are hungry. Of great concern is the impact of continued insufficient food intake, which can lead to a vicious circle where “mild starvation reduces appetite. Chronically underfed clients are in a state of mild starvation.”<sup>82</sup> This means that even if centres believe they can identify if residents are expressing hunger, there is still a need to ensure sufficient food intake without residents having to request more food. An absence of indications of hunger may be a result of reduced appetite due to mild starvation, rather than an indication of sufficient food intake.

Many centres did not provide specific information about how they deal with the inability of residents to request additional food. Most centres rely on a combination of frequent food offerings (ie snacks at morning and afternoon tea) and staff ability to recognise any indicators of hunger.

In contrast to these responses, the Performance Audit found that in most centres visited, there was “limited opportunity for residents to access food between meals.” In some cases, kitchens, or even dining rooms were locked. At one centre, “audit observed that residents began to queue before doors unlocked. No access to food or drink between meals.”<sup>83</sup>

## **5.10 Review of palatability and nutrition of meals**

Two additional problems identified in the Underweight Report as contributing to insufficient energy intake were that of low palatability of pureed or minced food, and the low nutrient density of diets. The commission sought information from the Department of Community Services as to arrangements in place to review and monitor the palatability and nutrition of meals provided. Again, the department did not provide any indication that there were standard arrangements for such reviews. Any such arrangements appear to be at the discretion of individual centres.

Responses provided from the centres tended to focus on the responsibility of Food Services for ensuring overall quality of food - both for palatability and nutrition. Some centres had established mechanisms for unit based feedback to Food Services on the quality of meals,<sup>84</sup> while others had committees or other forums for communication between Food Services and nursing staff

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<sup>82</sup> Underweight Report, pg 4

<sup>83</sup> Tomaree Centre, HRDDS

<sup>84</sup> For example, Riverside

(and in one case, consumer representatives).<sup>85</sup> However, all these responses dealt with overall food production. Only one response indicated that nutrition and palatability was considered in relation to the needs and preferences of individual residents, when menus and provision of meals was reviewed by a consultant dietitian.<sup>86</sup>

An example of the gap between ensuring palatability and nutrition of meals produced, and that of the food actually provided to residents is that food may be pureed in the unit (reducing its nutritional density) or pureed food mixed together before being given to residents (reducing its palatability).

The Underweight Report notes that “mixed purees are not served in the residential centres visited. However there is a tendency in some staff to mix the puree food together ...on the plate before commencing feeding.”<sup>87</sup> Community Visitors also reported that in some centres, staff mixed food together before feeding it to residents, even where foods had been pureed separately.

No responses from centres indicated that additional nutrients were provided to those residents whose diets were minced or pureed.

## **6. OUTSTANDING ISSUES OF CONCERN**

### **6.1 Absence of systematic approach to nutritional needs and issues**

The information reviewed highlights the absence of a systematic and consistent approach to identifying and addressing the nutritional needs of people with a significant disability. It is clear that there is no policy framework for ensuring that such a systematic approach is used in NSW. The results can be clearly seen in the variations in service practices, even within large residential centres all operated by one government department.

It is disturbing that such a situation could exist 4 years after local research demonstrated both the need for nutritional intervention, and the effectiveness of global dietary enhancements.<sup>88</sup> The most recent work carried out at WSDDS, through the Nutrition Project, further highlights the importance of systematic screening and assessment and multi-disciplinary interventions. This project also identified a number of organisational and staffing issues critical to resident safety, well-being and dietary/nutritional requirements.

The policy framework that exists within the Department of Community Services for people with disabilities fails to recognise the significance and range of issues impacting on the nutritional needs of people with a disability. As such it does

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<sup>85</sup> WSDDS

<sup>86</sup> Grosvenor Centre

<sup>87</sup> pg 4

<sup>88</sup> The Underweight Report 1993 and Project Renourish 1995

not identify procedures and safeguards to ensure an appropriate standard of care in relation to nutrition.

While some centres (notably HRDDS and WSDDS) have responded positively to the findings of work such as the Underweight Report and the Nutrition Project, these are local, discretionary initiatives. People with significant disabilities who live in other centres remain without access to assistance to meet their basic needs for adequate nourishment, and safe feeding. There is no monitoring mechanism in place to identify those deficiencies and ensure they are rectified.

A systematic and consistent approach to meeting the nutritional needs of people with significant disabilities is required in the following specific areas:

- policy and practice framework which identifies an approach to meeting the nutritional and health needs of people with significant disabilities;
- ensuring access to expert, specialist assistance - dietitians, nutritionists, speech pathologists, both for general advice and individual assessments and intervention;
- providing appropriate staff training and education in nutrition and feeding issues;
- regular and comprehensive screening of people at risk, to ensure timely and appropriate intervention;
- mechanisms for addressing organisational barriers to promoting nutrition and feeding support for people in care (eg staffing ratios, roster impact on mealtime practices); and
- mechanisms for monitoring the standard of care in relation to nutrition and feeding, and for ensuring service improvement.

## **6.2 Obesity and overweight**

This report has focussed on the needs of those people vulnerable to being underweight as a result of poor nourishment. However, bad nutrition can also lead to obesity which also carries significant health risks. The screening of residents of WSDDS identified that 33% of residents were overweight - 9.8% of these were obese, and 1.4% morbidly obese.

In the Underweight Report, Stewart reported that approximately 50% of people with developmental disabilities are overweight. A number of centres informed the commission that “overnourishment, rather than undernourishment is the problem”, particularly for those individuals living in campus or community ‘cottages’.<sup>89</sup>

Many of the strategies needed to ensure the nutritional health of people vulnerable to being underweight would also assist in the management of those people who are overweight or obese. Additionally, for some people who are overweight or obese, there will be a need to consider behavioural and lifestyle issues, as well as nutritional strategies.

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<sup>89</sup> For example, the Lachlan Centre

### **6.3 Implications for people in non-government services**

The recent local research has all focussed on government residential centres for people with developmental disabilities. However, there is no evidence to suggest that residents in the care of non-government providers are in any less need of support and intervention to ensure adequate and safe nutrition.

To the contrary, there is some evidence that people in non-government care may be even less likely to have access to needed expertise and assistance, than their peers in government centres. For example, the Performance Audit noted that “none of the non-government centres arranged for specialist dietary advice for individual residents or for menu planning in general.”<sup>90</sup> An additional risk faced by residents of non-government centres is the use of donated food to reduce service costs. The audit found that in these centres,

“(m)enu plans are adapted to utilise the donations which impacts on nutritional planning and resident choice. The quality of donated food is questionable. One centre reported that the donations received were generally foods which had reached their expiry date, or deemed not to meet commercial standards for some reason.”<sup>91</sup>

The commission recently conducted an investigation into a non-government residential centre following allegations that residents were being force fed by staff.<sup>92</sup> The investigation found that although many of the residents had difficulty eating and drinking, and some had programs outlining physical assistance and specific techniques required, there were not programs for all residents who required such assistance, and no evidence of systematic training for staff to implement the programs or any follow-up and monitoring of these programs.

### **6.4 Implications for people in community based accommodation**

People with multiple disabilities living in community based settings also require access to appropriate expertise for the assessment and intervention of nutrition and feeding issues. Many of the factors identified as contributing to chronic underweight status and risk of malnutrition are related to either the disability of the individual or the approach used to provide their nourishment. These risks would present regardless of the accommodation setting, although some of the identified issues (around staffing ratios, rushed mealtimes etc) may be more easily addressed. However, community based services may lack the necessary infrastructure to easily provide for the needed expertise and intervention. This need will increase as more people with significant disabilities move into the community from institutions.

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<sup>90</sup> pg 47

<sup>91</sup> pg 47

<sup>92</sup> Investigation into care and treatment of residents of Cram House (a service of the Illawarra Society for Crippled Children); also Inquiry into Cram House, 1997

## **6.5 Issues relating to exercise and medication**

Both exercise (or the lack of it) and the side effects of medication are identified in the Underweight Report as factors which can contribute to low appetite and therefore low food intake. As these are factors dependent on individual circumstances, the commission was unable to gather information in about service practices in dealing with these matters.

There are a number of points at which the issue of exercise is relevant to the nutritional needs of people with significant disabilities. These include the role of exercise in stimulating appetite, and preventing muscle wastage; and the need for physiotherapy for those people whose mobility limits their capacity to exercise independently.

The impact of medication on appetite and metabolism is also an important factor to be considered in individual interventions, highlighting the importance of a multi-disciplinary approach to working with people with significant disabilities.

Both exercise and medication issues impact on people who are overweight or obese, as well as those who are underweight or malnourished.

## **7. CONCLUSIONS**

The need for people to receive adequate nutrition to maintain a healthy physical state is a fundamental requirement which is often made complex in the face of significant or multiple disabilities. For people with multiple disabilities who are 'difficult' to feed, a lack of food intake can lead to a vicious and life threatening cycle of poor or incorrect feeding, insufficient food intake, food refusal or loss of appetite, weight loss and subsequent physical poor health. Undernourishment and its ensuing health implications are not the only risks faced by people with multiple disabilities. A more immediate (but related) risk is that of respiratory infections, choking, and possible death as a result of aspiration when food is provided incorrectly, or in the wrong form.

As significant as these risks are, the literature and research to date shows that they can be managed with a combination of expert input, methodical screening and intervention, and the management of organisational and staffing issues to ensure effective outcomes from intervention. The failure to act on such information to ensure adequate nourishment for all people with disabilities in residential services would leave service providers open to allegations of negligence.

The recommendations which follow represent the first steps to ensuring that people with significant disabilities receive services which attend to their physical comfort and basic need for adequate nutrition to maintain their health.

## **8. RECOMMENDATIONS**

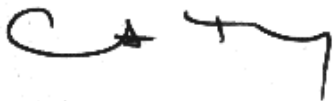
1. The Ageing and Disability Department establish a working party to assist in the development and implementation of the following recommendations. This working party should include membership of ADD, DOCS, relevant consumer or advocacy groups, government and non-government service providers, nutritionists/dietitians, and speech pathologists.
2. The Ageing and Disability Department establish a policy and practice framework to address the nutritional and feeding needs of people with disabilities, regardless of their accommodation setting. Consideration should be given to needs relating to obesity as well as those faced by people at risk of being underweight or malnourished. The development of this policy and practice framework should draw on the considerable work already done in this area.

Such a framework should include minimum practice standards and requirements for - regular health and nutritional screening of people with disabilities; appropriate multi-specialist review and input into interventions; and reviewing the quality and appropriateness of menu plans and food services.

3. Department of Community Services to develop its own detailed policies and procedures within the above framework, to ensure a consistent, co-ordinated and effective practices within departmental services.
4. Department of Community Services to examine those practices and systems in place within its own services which promote good nutritional screening and management, and ensure that residents in all its services have access to similar systems.
5. The Ageing and Disability Department immediately conduct a needs analysis and scoping study to determine the most effective way of providing appropriate specialist advice, assessment and intervention from dietitians and speech pathologists for people with disabilities, regardless of their accommodation setting. This should include examining options for the establishment of positions for dietitians, nutritionists and speech pathologists within services, and/or a range of contracting options using private or community practitioners.
6. Immediately following the needs analysis and scoping study referred to in recommendation 5, ADD and DOCS should move to ensure that the needed expertise is provided in each residential care setting to manage the nutritional needs of people with disabilities in a manner consistent the the most effective way identified by the scoping study.
7. The Ageing and Disability Department and the Department of Community Services ensure that appropriate training on safe feeding techniques is

provided to all staff working with people with significant disabilities. Such training should include feeding strategies to prevent aspiration and other problems, strategies to feed more effectively, and procedures for dealing with safety risks or incidents.

8. The Department of Community Services review and address all staffing issues which impact on mealtime practices in large residential centres. These include (but are not limited to) staffing ratios in units where residents have high levels of dependency for feeding; patterns of staff meal breaks; and roster arrangements for domestic staff.
9. Ageing and Disability Department should, as part of its monitoring role, develop mechanisms to determine that policies and procedures are being followed and that service improvement takes place, in relation to nutrition and mealtime practices.



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**REFERENCES:**

Audit Office of NSW and Community Services Commission Performance Audit Report: Large Residential Centres for People with a Disability in NSW 1997

Beange, H.; Stewart, L. and Gale, L. Project Renourish: a dietary intervention to improve nutritional status in people with multiple disabilities Australian and New Zealand Journal of Developmental Disability Vol 20, No 3, 1995

Conway, R; Bergin, L. and Thornton, K. Abuse and Adults with Intellectual Disability Living in Residential Services A report to Office on Disability on behalf of National Council on Intellectual Disability and the Australian Society for the Study of Intellectual Disability, 1996

Hunwick, H. and Dear, W. The Nutrition Project: A case study for screening, assessment and intervention. Western Sydney Intellectual Disability Support Group Inc, in liaison with NSW Department of Community Services 1997

Stewart, L. Report on the Problem of Underweight in Residential Centres for the Developmentally Disabled 1993

Stewart, L. Nourished or Undernourished ? A nutrition survey of underweight residents in NSW residential centres paper delivered at ASSID Conference 1993

Tomison, A.M. and Tucci, J. Emotional Abuse: the hidden form of maltreatment in Issues in Child Abuse Prevention; Australian Institute of Family Studies 1997