Dietitian and Nutrition Assistant Workforce Mapping

Final Report

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urbis

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Urbis's Public Policy team has received ISO 20252 Certification for the provision of public policy research and evaluation, social planning, community consultation, market research and communications research

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FIGURES:

TABLES:

TABLE 1 – LIST OF ACRONYMS

ACRONYMS	EXPANSION
AHA	Allied Health Assistant
LHD	Local Health District
MST	Malnutrition Screening Tool
NSW	New South Wales
OT	Occupational Therapist
QI	Quality Improvement
UK	United Kingdom
US	United States

The purpose of this document is to outline the methodology, approach and themes raised by allied health stakeholders as per the consultation phase of the NSW Ministry of Health's workforce planning methodology. It should be noted that the views expressed in the report are not necessarily those of the NSW Ministry of Health.

Executive Summary

INTRODUCTION

In May 2015, the Workforce Planning and Development Branch of NSW Health commissioned Urbis to undertake research to improve understanding of a key component of the allied health assistant workforce in NSW: the nutrition and dietetic assistant workforce. The current need to understand this component of the allied health assistant workforce is driven by the commencement by HealthShare NSW of a revised service delivery model for patient food services, the outcomes of which may have an impact on the roles of dietitian and nutrition assistants, including the role assistants play in taking meal orders. The development of this revised service delivery model, which is currently being trialled at Mona Vale hospital, was in part motivated by a desire to improve patient satisfaction with meals.

The key aim of this project is to improve understanding of the dietitian and nutrition assistant workforce through exploration of the following questions:

- What are the current roles of dietitian and nutrition assistants in NSW Health?
  - This question is answered in chapter 2
- What different service delivery models exist where dietitian and nutrition assistants exist?
  - This question is answered in chapter 3
- What different supervision models exist for the assistant workforce?
  - This question is answered in chapter 3
- What could a 'model' role description look like for dietitian and nutrition assistants?
  - This question is answered in chapter 5
- How will the proposed service delivery reforms impact the procedures for nutrition risk assessment?[1]
  - This question is answered in chapter 4

The research design incorporated both qualitative and quantitative data collection. A brief literature review and documentation review was conducted following several early key informant interviews. Subsequently, 53 people took part in focus groups or workshops, and 513 dietitians and dietitian assistants completed online surveys.

It is acknowledged that a number of questions have arisen as a result of the proposed reforms including "is the new food service delivery model dependent upon food services staff taking meal orders, or could the new technology be implemented while dietary support workers retain the task of taking patient meal orders?". It should be noted that this question was out of scope for the research and therefore has not been answered in the findings.

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[1] Please note that the following definitions for nutrition risk assessment and screening have been adopted for this report:
- **Informal nutrition risk assessment:** Informal questioning and observation during direct patient interaction that helps identify barriers to nutrition intake in order to initiate corrective action(s) (e.g. consideration of dexterity, vision, hearing, comprehension, literacy, nutrition knowledge, dentition etc.)
- **Formal nutrition assessment:** A comprehensive process to define a person's nutritional status, identify nutrition-related problems and help determine appropriate mitigation actions. Formal nutrition assessment must be carried out by a dietitian.
- **Formal nutrition screening:** The use of a validated tool to determine if a patient is at nutritional risk (e.g. Malnutrition Screening Tool, Malnutrition Universal Screening Tool, Mini Nutritional Assessment). Nutrition screening is a rapid, simple and general procedure that can be carried out by nursing, medical or other clinical staff.

NOTES ON THE TEXT:

1) While the aim of this project was to map the dietitian and nutrition assistant workforce, consultation has identified that these workers are employed under a range of titles, with overlapping job descriptions. In order to describe the general assistant role, without identifying specifically with a particular job title (because the same job title could mean different things in different LHDs), we have used the term 'dietary support worker' to describe the collective members of the NSW dietitian and nutrition assistant workforce. Examples of titles included under this banner are: dietitian assistant, diet aide, nutrition assistant, and allied health assistant working in dietetics.

2) We have followed the convention outlined in the Commonwealth Style Guide and do not capitalise titles unless they refer to a proper noun; thus, 'a Certificate IV in Allied Health Assistance', but 'a qualification in allied health'. Likewise, a 'dietitian' but 'Head of Dietetics at Named Hospital'.

3) We understand that dietary support workers, in addition to working in LHD dietetics departments, are employed in LHD food services departments, and Health Share NSW. To ease the reading of the report, we have used the term 'food services' to refer collectively to both LHD food services and Health Share NSW when that is the meaning of the text, and 'LHD food services' or 'Health Share NSW'; when they are being discussed separately.

FINDINGS

Staff employed in a dietary support role, whether called a dietitian assistant, diet aide, nutrition assistant, or allied health assistant working in dietetics, commonly work across one or more of the following domains: delegated direct patient care, delegated indirect patient care, communication, administration, and education.

The research has identified that dietary support workers, however named, undertake a wide range of tasks, and that 80% of them undertake clinical tasks more than once each shift. Conversely, a very small percentage of support workers are directly involved in the delivery of meals, collecting of meal trays, and associated tasks. From this it appears that a large component of the dietary support workers' time is spent on tasks defined as direct patient care. It should be noted that this includes the taking of meal orders.

Dietary support workers employed under the supervision of a dietitian spend a large proportion of their shift taking patient meal orders, and it is in completing this task that they have the most direct contact with patients. There is variance in opinion of whether the taking of patient meal orders constitutes a clinical task, with the dietetics workforce (including clinical dietitians and support workers) suggesting that therapeutic outcomes could be influenced while taking orders, and food services staff (including management and frontline staff) suggesting that the clinical aspect of this task had been diminished significantly since the introduction of computerised dietary management packages.

Dietetic staff (including dietitians and support workers) reported that nutrition risk assessments can be performed informally by dietary support workers when they are taking patient meal orders, or at other times in which they have direct contact with patients. In addition to this direct engagement with patients, dietary support workers employed under the supervision of a dietitian also undertake delegated clinical tasks including patient monitoring and assessment, liaison with other clinicians, communication and liaison with food services teams, health promotion and education with patients and their families, and administrative tasks.

The roles and responsibilities of dietary support workers are influenced by:

- **Employer and supervisor:** Dietary support workers employed and managed through Health Share NSW play a less sizeable (although not non-existent) and less defined role in delegated patient care.

- **Location, staffing, and infrastructure:** Dietary support workers working in regional hospitals and in facilities without computerised dietary management packages typically have an expanded clinical role when compared to other support workers.

- **Training, experience and personal attributes:** Delegation to support workers is a complex and multifaceted process that depends crucially on the dietitian's (or other manager's) assessment or judgement of the support worker's current education, experience, and competency.

Under the proposed service delivery reforms, dietetic staff (i.e. support workers supervised by clinical dietitians) will not be responsible for taking patient meal orders. There is disagreement about whether taking patient meal orders is crucial to the conduct of nutrition risk assessments:

- Dietetic staff (including dietitians and support workers) typically argued that the process of taking meal orders was crucial to informal nutrition risk assessment, as it allowed support workers to build rapport and, importantly, make a clinical assessment of patients.

- Food services staff typically argued that dietary support workers could provide this service (i.e. malnutrition screening) without taking on responsibility for patient meal orders.

Fundamentally, a key question to be answered in determining food service delivery models is whether food is considered a treatment modality or a housekeeping matter, part of the hospitality offered to a patient during their stay in hospital. Most of those consulted would agree that food service in a hospital is both treatment and hospitality. There are essential roles for both food services and for dietetics departments in food planning, preparation and delivery. These have developed over time and are organised differently in different locations depending on the needs and resources of the local environment.

The two primary factors that distinguish roles, according to research participants, are the extent to which a task is therapeutic or procedural, and the extent to which a person has delegated decision-making authority. Across these two domains there is a core scope of work generally conducted by most dietary support workers. There are other tasks which relate more closely either to food service delivery, or dietetic therapy, depending on the line management and location of the individual staff member.

At the same time, one of the key attributes of the support worker position has been identified as the flexibility to undertake a wide range of activities across the spectrum between food services and clinical nutrition. Stakeholders strongly advocated for the role's contribution as a bridge between the therapeutic and the procedural activities associated with food preparation and consumption. Put simply, the dietary support worker provides an essential liaison function not currently played by any other role.

While maintaining this flexibility of role to move across the spectrum as required, there are clear distinctions between those managed under a food services paradigm and those managed under a therapeutic paradigm. This is primarily in the extent to which staff work on more administrative and procedural tasks, or engage more with the patient and with the multi-disciplinary clinical team. Dietary support workers who are managed by dietetics department reportedly wear a clinical uniform distinguishing them as part of the clinical team, and are provided with opportunities for continuing professional development through participation in ward rounds, formal and informal discussions with dietitians and other clinicians, and regular clinical supervision. Dietary support workers managed by food services often have no direct, or limited, contact with dietitians and focus primarily on the procedural aspects of food planning, preparation and delivery.

CONCLUSION

1) Given the larger, national trend towards the increased use of delegated roles such as allied health assistant roles, there will be value in defining the dietary support worker roles in NSW more clearly, and particularly in clarifying the nomenclature. Whether a support worker works within the paradigm of hospitality or therapy, there will be an overlap of certain tasks and activities; this could be more clearly aligned with a patient-centred approach that determines how each role contributes to the overall nutritional wellbeing of the patient.

2) The weight of evidence from this project suggests that taking meal orders is an opportunity for dietary support workers to undertake monitoring, observation, and informal nutrition education with patients. It is not the taking of a patient's meal order in itself that forms the clinical task; rather, this task provides a structured, regular face to face encounter with a patient which can allow the support worker to undertake an assessment of the patient, or the patient to voice a concern or complaint.

This encounter also allows the support worker to respond immediately to issues that might arise regarding food consumption, including taste and texture, nausea and inability to take food, difficulties in swallowing, or other physical responses to food intake. It is not that the staff member needs to be trained and experienced in diet and nutrition in order to take the order itself, in terms of the functional activity of recording meal orders. The concern has been expressed that an untrained worker will not pick up the unspoken clues regarding malnutrition, dehydration, or changes in the physical condition which may warrant changes to the patient's diet, or further clinical assessment.

3) Research participants welcomed the increasing use of technology to increase the efficiency of meal ordering, and agreed that diminishing the period of time between ordering and serving a meal is likely to reduce waste and increase appropriateness. The real question is who should hold the wireless device and stand in front of the patient to take the order.

4) There are many reasons that have been given for delegating the meal ordering to food service staff, including increasing patient and food service staff satisfaction, linking meal ordering more closely to the food preparation chain, and increasing efficiency. No reasons related to the therapeutic benefits for patients have been given, confirming that the primary reason for the proposed changes to the service delivery model is a logistical one. At the same time, these changes could have significant impact on the ability of dietary support workers to support patients. Stakeholders have also acknowledged a potential impact on the clinical risks associated with nutritional therapy, if dietary support workers are further removed from the task of meal ordering. Dietitians in particular are concerned to ensure that, if the changes are implemented more widely, clinical governance is clarified to maintain a clear line of responsibility for managing risk associated with food intake.

5) Stakeholders considered that the use of the assistant workforce to improve task allocation through appropriate role delegation provides efficiencies and frees up the dietitian to undertake more complex clinical tasks. Dietitians also considered that there is immense value in having the dietary support worker take the meal order because this in itself provides an efficiency: the meal order has to be taken, and patients need to be assessed, so the support worker does both at the same time. Much of the informal and formal feedback provided to dietitians by dietary support workers is gained through the conversations held during the meal order process.

6) In some locations, where there are no dietary support workers working under dietetics departments, dietitians themselves undertake tasks normally delegated to an assistant. Research participants noted that in this situation there is still an attempt to liaise across the two areas – food services and dietetics – however this is unwieldy and information is not easily shared simply due to the burdens of workload and the lack of a clear communication channel.

7) Stakeholders should consider how information regarding food intake, any reported problems with consumption or diet choice, and a range of other important clinical information will be communicated to dietitians if support workers who are taking meal orders are not in direct reporting lines to dietitians. The importance of the dietary support worker as a liaison between the two departments is considered to be of such importance by dietitians that, if meal ordering is removed from their tasks, other opportunities will need to be found to ensure that the liaison continues to occur so that information flows freely across the continuum from meal ordering through consumption to nutrition monitoring.

RECOMMENDATIONS

Recommendation 1 Establish consistent job titles and job descriptions across the spectrum of dietary support worker roles.

Recommendation 2 Conduct a study across different hospital settings to audit nutrition risk assessment activity, to clarify the extent to which dietary support workers actually use the menu ordering task to conduct therapeutic activities, compared to the demands of completing the meal ordering rounds. This audit should also analyse monitoring and other risk assessment activities which take place at other times of the day. This audit could be used to clarify the best way to schedule monitoring activities, should dietary support workers not continue to take meal orders.

Recommendation 3 Should the trial be expanded to other hospitals, the food services project team should work with dietitians and dietary support workers to design a job description which fully describes the wide range of alternative tasks, to ensure that the assistant workforce remains fully deployed and that the staffing allocation is not lost from dietetics.

ADDITIONAL ACTION ITEMS FOR CONSIDERATION

Action item 1 Prior to implementation of the revised service delivery model, food services staff who will have a customer-facing role should, at a minimum, receive training in basic nutrition and customer service.

Action item 2 A formal clinical governance model (including managerial and clinical supervision) should be developed for dietary support workers. This model should be aligned with the NSW Ministry of Health Allied Health Assistant Framework, and should include clear lines of managerial and clinical supervision responsibilities for dietary support workers working within both food services and clinical dietitians.

THIS REPORT

This report is structured to present the research findings according to the aims of the project, as follows:

Chapter 1: Introduction and methodology

Chapter 2: Current roles of dietary support workers in NSW

Chapter 3: Personal and contextual influences on the roles of nutrition and dietetic assistant

Chapter 4: Impact of proposed service delivery reforms on procedures for nutrition risk assessment

Chapter 5: Conclusion and recommendations

1 Introduction

1.1 INTRODUCTION

In May 2015, the Workforce Planning and Development Branch of NSW Health commissioned Urbis to undertake research to improve understanding of a key component of the allied health assistant workforce in NSW: the nutrition and dietetic assistant workforce. The current need to understand this component of the allied health assistant workforce is being driven by the commencement by HealthShare NSW of the a revised service delivery model for patient food services, the outcomes of which may have an impact on the roles of dietitian and nutrition assistants, including the role assistants play in taking meal orders. This revised service delivery model is currently being trialled at Mona Vale hospital.

The key aim of this project is to provide improved understanding of the dietitian and nutrition assistant workforce. Critical questions that this research project will answer include:

- What are the current roles of dietitian and nutrition assistants in NSW Health?
  - This question is answered in chapter 2
- What different service delivery models exist where dietitian and nutrition assistants exist?
  - This question is answered in chapter 3
- What different supervision models exist for the assistant workforce?
  - This question is answered in chapter 3
- What could a 'model' role description look like for dietitian and nutrition assistants?
  - This question is answered in chapter 5
- How will the proposed service delivery reforms impact the procedures for nutrition risk assessment?
  - This question is answered in chapter 4

This report summarises the findings from consultation with nutrition and dietetic assistants, clinical dietitians, and stakeholders representing workforce planning, food services, nutrition and dietetics, and the Mona Vale pilot project working group. The research design incorporated both qualitative and quantitative data collection.

1.2 BACKGROUND

A number of international trends have influenced the development of the allied health assistant workforce over the past few decades. The increasing demand for, and complexity of, health services has led to increasing specialisation within the health workforce and, as a result, the development of new roles to differentiate specialised from less complex clinical tasks (Duckett 2011; Lizarondo, Kumar, Hyde & Skidmore, 2010). Globally, an ageing population has meant that health care consumers are living longer with chronic and complex diseases, requiring greater use of health services per capita. In addition, over the past several decades patient expectations have shifted too, with patients becoming active participants (or *consumers*) rather than passive receivers of care. With these changes, healthcare services (including NSW Health) are under growing pressure to ensure that there are an adequate number of health professionals and paraprofessionals to provide appropriate and timely care to all patients. This has, for example, resulted in qualified health care providers regularly allocating clinical and non-clinical tasks to other practitioners (see for example Kersten et al, 2007). In addition, evidence suggests that the boundaries between groups of health care professionals (e.g. doctors and physiotherapists) are shifting and blurring, with 'role substitution' and 'role enhancement' becoming relatively commonplace, especially amongst allied health professionals (see for example Daker-White et al, 1999).

The development of an allied health assistant (AHA) or support worker role is one way in which health services have dealt with the growing demand for care and the increase in clinical specialisation. The UK National Health System, for instance, currently employs both health care support workers – who are not required to have formal training or hold recognised qualifications – and assistant practitioners. Assistant practitioners are higher-level support workers introduced to complement the work of registered professionals in hospital and community settings. Assistant practitioners are required to hold formal qualifications, are directly supervised by a registered practitioner, and have a clear career progression pathway. Governments across Australia have also recognised the importance of developing an allied health assistants' workforce. For example, the Victorian Department of Health's approach to implementing an assistant workforce is largely based on the trialling and implementing of allied health assistants. In NSW, the strategy to realign the health workforce with new models of care and to development a healthcare assistant workforce has been well-documented and supported, and, after extensive research, NSW Health released an Allied Health Assistant Framework in August 2013.

While there is an increasing recognition of the importance of allied health assistants, an opportunity exists for further systematic analysis of this workforce alongside service delivery reforms. The available evidence does, however, suggest that the introduction of allied health assistants can result in significant healthcare benefits, including benefits to process and outcomes. These benefits comprise increased patient satisfaction, increased intensity of clinical care, more time for allied health professionals to concentrate on complicated tasks, and improved clinical outcomes (see Lizarondo, Kumar, Hyde & Skidmore, 2010 for review of literature). Evidence further suggests that the introduction of allied health assistants is a cost-effective addition to the allied health workforce (Clinical Education & Training Institute, 2011). Nevertheless, there appears to be some barriers to the successful introduction of allied health assistants, most notably: ongoing uncertainty regarding the scope of roles and responsibilities, lack of clarity regarding training and career pathways, and protectionism by allied health professionals. These barriers have all been shown to have the potential to negatively impact quality of care and patient safety. Lizarondo and colleagues (2010, p.152) suggest that 'a clear demarcation of the roles and responsibilities should therefore address the issue of professional status and security, which can lead to adequate and appropriate utilisation of AHA service'.

The Australian and international literature outlined in Appendix A suggests that there is no one 'model' of service delivery for dietary support workers, with significant variation in roles and responsibilities, and supervision, observed across jurisdictions. Domains of work commonly undertaken by dietary support workers include providing direct and indirect care to patients, administration tasks, and helping to facilitate cross-agency working. The scope of role appears to be influenced by personal and contextual factors including education (credentials or qualifications), knowledge and skills, level of experience and on-the-job training, level of supervision, and type and level of services provided by the facility in which they work. In addition, the levels of complexity and responsibility afforded to dietary support workers across jurisdictions are most strongly driven by the formal education requirement of their position, with dietary support workers registered in the US having the highest educational requirements and the highest level of responsibility of the three countries profiled (i.e. Australia, the United Kingdom, and the United States).

NOTES ON THE TEXT:

1) While the aim of this project was to map the dietitian and nutrition assistant workforce, consultation has identified that these workers are employed under a range of titles, with overlapping job descriptions. In order to describe the general assistant role, without identifying specifically with a particular job title (because the same job title could mean different things in different LHDs), we have used the term 'dietary support worker' to describe the collective members of the NSW dietitian and nutrition assistant workforce. Examples of titles included under this banner are: dietitian assistant, diet aide, nutrition assistant, and allied health assistant working in dietetics.

2) We have followed the convention outlined in the Commonwealth Style Guide and do not capitalise titles unless they refer to a proper noun; thus, 'a Certificate IV in Allied Health Assistance', but 'a qualification in allied health'. Likewise, a 'dietitian' but 'Head of Dietetics at Named Hospital'.

3) We understand that dietary support workers, in addition to working in LHD dietetics departments, are employed in LHD food services departments, and Health Share NSW. To ease the reading of the report, we have used the term 'food services' to refer collectively to both LHD food services and Health Share NSW when that is the meaning of the text, and 'LHD food services' or 'Health Share NSW'; when they are being discussed separately.

1.3 METHODOLOGY

Data collection for the mapping of the dietetic and nutrition assistant workforce comprised the following research activities:

- Data and literature review
- Qualitative research activities
  - Focus groups (n=2) with dietary support workers
  - Focus groups (n=2) with food services staff
  - Workshops (n=2) with stakeholders
  - In-depth telephone interviews (n=6) with stakeholders
- Quantitative research activities
  - Online survey with clinical dietitians
  - Online survey with dietary support workers.

All research instruments are attached at Appendix B.

1.3.1 LITERATURE REVIEW

A literature review was undertaken to assist with the task of identifying:

- The roles and functions of dietitian and nutrition assistants in health services and delivery of food services
- Different workforce models
- Relationship of dietitian and nutrition assistants to clinical dietitians and food services.

A multi-pronged approach to identifying and collecting literature was adopted to ensure all relevant material was covered. This approach included database searches, internet searches, and consultation with key informants. All Australian material of direct relevance was considered, as well as a selection of key relevant overseas material, mainly focusing on the United Kingdom and North America. Only material produced within the past 10 years was included in the review.

DATABASE SEARCHES

The following databases were searched for relevant literature:

- Academic Search Complete
- The Australia/New Zealand Reference Centre
- MEDLINE
- SocINDEX with Full Text
- Health Policy Reference Centre
- Social Sciences Full Text.

The search strategies used were designed to find as many articles as possible relating to the topic area. While this produced a large number of results, including many articles falling outside the scope of the review, it ensured that a broad range of relevant literature was found. A copy of the final literature review can be found at Appendix A.

INTERNET SEARCHES

Websites for government agencies and non-government nutrition and dietetics and allied health groups (including professional associations) were searched for literature relating to assistant workforces, and for references to such literature.

STAKEHOLDER RECOMMENDATIONS

In an effort to ensure that all relevant literature was included, three key stakeholders were asked to nominate any published or unpublished literature that they considered worthy of inclusion in the review. Two stakeholders represented nutrition and dietetics and one represented food services.

1.3.2 FOCUS GROUPS WITH DIETETIC SUPPORT STAFF AND FOOD SERVICES STAFF

A series of four focus groups were conducted with dietetic support staff (two groups) and food services staff (two groups). Discussions were held at both metropolitan and regional locations to provide a diversity of experience and perception. Each focus group lasted 1-1.5 hours.

Participants were recruited with the assistance of either senior dietetic staff (in the case of the dietetic support staff groups) or HealthShare NSW managers (in the case of the food services groups). Fieldwork took place from 28 July to 4 August 2015. In total, 27 participants took part in this phase of the research. The table below provides a summary of the sample structure.

TABLE 2 – FOCUS GROUP SAMPLE STRUCTURE

	DIETARY SUPPORT WORKERS	FOOD SERVICES STAFF	LHDS REPRESENTED
Concord Hospital	8[2]	7	Sydney Illawarra Shoalhaven Central Coast South Eastern Sydney South Western Sydney Northern Sydney
Lismore Hospital	5[3]	7	Northern NSW

1.3.3 STAKEHOLDER CONSULTATION

Urbis conducted stakeholder workshops at Lismore Hospital and Concord Hospital. The workshop at Lismore Hospital took place on 29 July 2015 and the workshop at Concord Hospital took place on 4 August 2015. Each workshop lasted 1.5-2 hours. Telephone interviews were also conducted with a small number of stakeholders unable to attend the workshops. Telephone interviews lasted for 20-45 minutes. Please note that group activities were only included in workshops.

Participants for this phase of the study were identified by the NSW Ministry of Health and selected for their ability to comment on the workforce. Participants included representatives from workforce planning, food services, nutrition and dietetics, and the Mona Vale pilot project working group.

[2] Four participants employed by HealthShare and four participants employed by LHD or Specialty Network.

[3] Three participants employed by HealthShare and two participants employed by LHD or Specialty Network.

Urbis consulted with a total of 20 stakeholders, 12 of whom participated in the Concord workshop and eight of whom participated in the Lismore workshop. Telephone interviews were conducted with a further seven stakeholders. The table below provides a summary of the sample structure.

TABLE 3 – STAKEHOLDER GROUPS REPRESENTED IN CONSULTATION

STAKEHOLDER GROUP	CONCORD HOSPITAL	LISMORE HOSPITAL	TELEPHONE INTERVIEWS
Workforce planning	2	0	1
Food services	1	3	0
Nutrition, dietetics and speech pathology	6	4	2
The Mona Vale pilot project working group	1	0	2
Education and training	1	0	0
Allied Health	0		2
Nursing	0	1	0

1.3.4 ONLINE SURVEY WITH CLINICAL DIETITIAN AND NUTRITION AND DIETARY SUPPORT WORKER WORKFORCES

Urbis designed two 15-minute online surveys: the first survey explored the perceptions and experiences of clinical dietitians and the second survey explored the perceptions and experiences of dietary support workers. Survey links were distributed to all clinical dietitians working within the NSW Ministry of Health. Clinical dietitians were directed to pass the questionnaire link to support workers.[4] The number of dietitians employed by the NSW Ministry of Health at June 2015 by LHD is shown in Table 4

TABLE 4 – NSW DIETITIANS WORKFORCE BY LHD (JUNE 2015)

LHD	FULL-TIME EQUIVALENT
CCLHD	23.65
FWLHD	1.83
HNELHD	84.31
HPATH	0.61
HSS	4.95
ISLHD	35.24
MLHD	15.07
MNCLHD	14.84
NBMLHD	20.41
NNSWLHD	17.19
NSLHD	50.26
SCHN	26.83
SESLHD	51.97
SNSWLHD	9.16

[4] Note that email addresses are not available for dietetic support workers employed by NSW Health.

LHD	FULL-TIME EQUIVALENT
SWSLHD	51.66
SYDLHD	55.50
VICIN	3.42
WNSWLHD	20.67
WSLHD	33.66
Grand Total	**521.23**

Due to significant variation in titles and overlapping job descriptions, it is difficult to estimate the number of dietary support workers employed in NSW hospitals. However, a survey of allied health assistants performed by NSW Health in 2012 suggests that there were at least 142 dietitian assistants employed by LHDs (i.e. not HealthShare) in 2012.[5]

The dietitian survey was completed by 299 clinical dietitians. The dietary support worker survey was completed by:

- 110 dietitian assistants
- 26 nutrition assistants
- 52 diet aides
- 9 dietitian technicians
- 107 'Others' (including food services staff, hospital assistants, community dietitians, diet supervisors and management staff).

Respondents who identified as 'other' were included in the analysis if it their role was deemed to fit within the broad category of dietary support worker. Roles included in the analysis primarily comprised diet supervisor and dietitian and nutrition assistant, bringing the total sample size for this survey to 214. Role excluded from the analysis included food kitchen assistant, hospital assistant, community dietitian, and management.

Both surveys were in field between 16 July and 6 August 2015.

1.4 PRESENTATION OF FINDINGS

1.4.1 QUALITATIVE RESEARCH

Interviews and focus groups were recorded and transcribed for analysis. A thematic analysis approach was taken with transcripts read iteratively to identify common themes and to develop a structure of perspectives from different disciplines, locations, and roles. A qualitative research approach does not allow for the number of participants holding a particular view on individual issues to be quantified. This approach therefore provides an analysis of themes and reactions among research participants rather than exact proportions of participants who held a particular perspective.

In this report, *qualitative research* refers collectively to data collected during the in-depth interviews, focus groups, and workshops. When data has been collected through a single data collection method, this approach will be stated.

[5] Survey results available online: http://www.health.nsw.gov.au/workforce/alliedhealth/Documents/NSW-Health-2012-AHA-Survey-Results.pdf

Quotes have been provided throughout the report to support the main results or findings under discussion.

1.4.2 QUANTITATIVE RESEARCH

Percentages presented in the report are based on the total number of valid responses made to the question being reported. In most cases, results reflect those respondents who had a view and for whom the questions were applicable. 'Don't know' and 'Unsure' responses have only been presented where this aids in the interpretation of the results.

Overall percentage results for questions to the clinical dietitians' survey (answered by 299 respondents) have a degree of sampling error (i.e. confidence interval) at the 95% level of statistical confidence of +/- 6 percentage points (pp). That is, there is a 95% probability (abstracting from non-sampling error) that the percentage results will be within +/- 6pp of the results that would have been obtained if the entire population (i.e. all clinical dietitians employed by NSW Health) had responded. Higher degrees of sampling error apply to questions answered by fewer respondents.

Overall percentage results for questions to the nutrition and dietetic assistants' survey (answered by 214 respondents) have a degree of sampling error (i.e. confidence interval) at the 95% level of statistical confidence of +/- 6 percentage points (pp). That is, there is a 95% probability (abstracting from non-sampling error) that the percentage results will be within +/- 6pp of the results that would have been obtained if the entire population (i.e. all dietary support workers employed by NSW Health) had responded. Higher degrees of sampling error apply to questions answered by fewer respondents.

Percentage results throughout the report may not sum to 100% due to rounding or due to the acceptance of multiple responses for some questions.

1.5 PROFILE OF SURVEY RESPONDENTS

Key characteristics of survey respondents are presented below

TABLE 5 – PROFILE OF RESPONDENTS BY AGE

AGE	DIETITIANS	DIETARY SUPPORT WORKER
16-24 years old	12	1
25-34 years old	117	26
35-44 years old	56	36
45-54 years old	35	43
55-64 years old	10	35
65 years or older	2	2
I'd prefer not to say	10	8
Not specified	57	63
Total	**299**	**214**

TABLE 6 – PROFILE OF RESPONDENTS BY GENDER

GENDER	DIETITIANS	DIETARY SUPPORT WORKER
Male	13	3
Female	219	142
I'd prefer not to say	10	4
Not specified	57	65
Total	299	214

TABLE 7 – PROFILE OF RESPONDENTS BY YEARS PRACTICING AS A DIETITIAN

YEARS OF PRACTICE	DIETITIANS
Less than two years	23
3-5 years	55
6-10 years	55
More than 10 years	103
I'd prefer not to say	6
Not specified	57
Total	**299**

TABLE 8 – PROFILE OF DIETARY SUPPORT WORKERS BY QUALIFICATIONS

COURSE	COMPLETED	COMPLETING	DON'T KNOW
Dietary Practices Certificate	58	20	0
Certificate III in Health Service Assistance (Nutrition and Dietetics)	58	1	3
Certificate III in Allied Health Assistance	9	24	0
Certificate IV in Allied Health Assistance	27	4	0
Other relevant qualification	38	8	1
Total	**190**	**57**	**4**

TABLE 9 – PROFILE OF RESPONDENTS BY FORMAL EDUCATION

FORMAL EDUCATION	DIETITIANS	DIETARY SUPPORT WORKER
Under Year 10	0	7
Year 10 or equivalent	0	17
Year 11 or equivalent	0	8
Year 12 or equivalent	0	11
TAFE, diploma, certificate	0	68
Undergraduate university	107	16
Post-graduate university	130	18
Other	2	2
I'd prefer not to say	2	1
Not specified	58	66
Total	**299**	**214**

TABLE 10 – PROFILE OF RESPONDENTS BY EMPLOYER

EMPLOYER	DIETITIANS	DIETARY SUPPORT WORKER
LHD/ Speciality Network	231	82
Health Share	3	57
Other (please specify)	2	4
Don't know/ not sure	4	5
Not specified	59	66
Total	**299**	**214**

2 Current roles of dietary support workers in NSW Health

2.1 KEY POINTS

- There are a variety of ways in which dietary support workers are working (whether called a dietitian assistant, diet aide, nutrition assistant, or allied health assistant working in dietetics).
- Dietary support workers in NSW commonly work across one or more of the following domains: delegated direct patient care, delegated indirect patient care, communication, administration, and education.
- Dietary support workers spend a large proportion of their shift taking patient meal orders, and it is in completing this task that they have the most direct contact with patients.
- There is variance in opinion regarding whether the taking of patient meal orders constitutes a clinical task, with the dietetics workforce (including clinical dietitians and support workers) suggesting that therapeutic outcomes could be influenced while taking orders, and food services staff (including management and frontline staff) suggesting that the clinical aspect of this task had been diminished significantly since the introduction of computerised dietary management packages.

2.2 A VARIED WORKFORCE

As noted above, there is significant evidence to suggest that assistant health workforces can be complex and difficult to conceptualise, with roles and titles of common workforce elements differing significantly depending on personal and contextual influences (see literature review in Appendix A). The results of the current study provide further evidence in support of this view. For example, stakeholders consistently suggested that dietary support workers (whether they are called a dietitian assistant, diet aide, nutrition assistant, or allied health assistant working in dietetics) are being utilised in a wide variety of ways across NSW. Stakeholders were, in addition, quick to point out that title, employer, experience, or formal qualifications alone were not a predictor of roles or responsibilities, and that this inconsistency could be challenging at times.

> *I know it's complicated but if you could have the titles meaning the same things, that would help communication across LHD staff. So I know that's tricky because in different districts there's different models but you know, the fact that you don't know what you're talking about at any one point in time is really quite challenging*
>
> Stakeholder

There was also significant variation in the descriptions of a 'typical shift' outlined by dietary support workers in focus groups, providing further evidence of role inconsistency. Dietary support workers commonly expressed surprise at the tasks being undertaken by support workers with the same or similar titles to their own working in different hospitals. For example, some dietary support workers reported that they were forbidden from touching the patients, while others stated that they routinely carried out physical measurements as part of malnutrition screening.

> *Yeah I do MST [Malnutrition Screening Tool], I weigh the patients, I do QIs [Quality Improvements]. But at [other hospitals] they don't do that, they're quite hesitant, because they don't know…*
>
> Dietary support worker

Support workers who had been employed across multiple hospitals further reflected that there was little overlap in the role from site to site. Adding to the confusion, there appears to be some commonality in the roles and responsibilities of dietary support workers and food services staff, especially in smaller hospitals. Most notably, food services staff reported undertaking limited delegated patient care (e.g. applying clinical/ therapeutic diet protocols), including tasks listed under the existing scope of practice for nutrition and dietetic assistants.

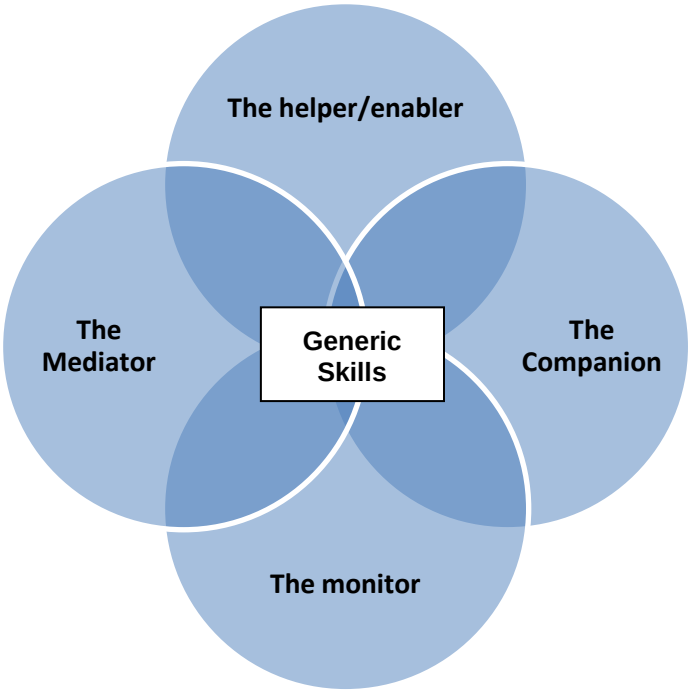
Consistent with Australian and international literature (see Appendix A), the data from this research project suggest that dietary support workers in NSW commonly work across one or more of the following domains: delegated direct patient care, delegated indirect patient care, communication, administration, and education. These domains are broadly aligned with those proposed by Moran et al (2011; see Table 11 below and literature review at Appendix A). Variation in role, it was reported, depended on the amount of work, if any, performed in each of these domains. For example, a dietary support worker with an undergraduate degree in nutrition stated that she spent the vast majority of her time working with patients, and considered herself to be a vital part of the allied health workforce. Another support worker, in contrast, suggested that her time was primarily devoted to technical and administrative tasks, and explicitly stated that she did not possess any detailed clinical knowledge. However, both were employed in roughly the same role.

TABLE 11 – FOUR DOMAINS OF THE SUPPORT WORKER ROLE (MORAN ET AL 2010)

DOMAINS OF WORK	EXAMPLES
Direct care	Working directly with patients, usually in roles that have a therapeutic focus, providing personal care, medical assistance and emotional and social support.
Indirect care	Assisting with treatment planning/reviewing care programs and monitoring progress.
Administration	General administration duties, admission and discharge process, checking and maintaining equipment
Facilitation	Encourage cross-agency working, continuity of care, support professionals, promote interdisciplinary communication, feedback to professionals and informal assessment of patient change

It should be noted that Moran et al also identified four key attributes of support workers, all of which are shown in Figure 1, below (see literature review at Appendix A for further discussion of these attributes).

FIGURE 1 – ROLES AND ATTRIBUTES OF THE SUPPORT WORKER ROLE



The remainder of this chapter will further consider the tasks that sit under each domain of the dietary support worker, and the following chapter will consider the personal and contextual factors which appear to drive variation in support worker roles. Without this combined understanding, it is impossible to assess whether or not dietary support workers, as a group of practitioners, are capable of meeting current and changing expectations of policy writers, service commissioners, and service managers alike. Furthermore, a better understanding of how and why the role of support worker varies in different health settings will help to inform workforce planning at various sites.

2.3 DOMAINS OF THE DIETARY SUPPORT WORKER

DELEGATED DIRECT PATIENT CARE

Put simply, direct care encompasses tasks undertaken by support workers that involve working directly with a client. Most commonly, these tasks have a therapeutic or clinical focus. The allied heath assistant literature provides a myriad of examples of direct care roles across assistant workforces, including providing clients with rehabilitation programs, personal care, nursing care, equipment, emotional support, and therapeutic intervention (Moran et al, 2011).

Dietary support workers almost universally stated that a large proportion of their shift was spent taking patient meal orders, and that it was in completing this task they had the most direct contact with patients. Some support workers reported that during this contact they were able to ensure that clinical diet protocols are being followed, to identify inappropriate orders, and to assess whether there are any patients at nutritional or hydration risk. Support workers also suggested that the taking of patient meal orders gave them an opportunity to provide nutritional advice to patients (and their family), including patients on a full diet. This advice varied from reminding patients about the importance of eating healthy food while in hospital, to suggestions for reducing nausea while eating, and more technical advice around vitamin and nutrient content of particular foods. Questions that the dietary support worker was not able to answer (including questions about clinical diets) were reportedly efficiently escalated to a clinical dietitian or other applied health or medical professional.

> *Well if you see, you can sort of tell when someone is malnourished. I can tell when someone is malnourished and I go to the dietitian and say I think this person is malnourished and then they'll go and they'll see and then they'll go okay we're going to put them on supplements.*
>
> Dietary support worker

Support workers reported that if they noticed a problem with a patient while distributing and collecting menus, they would generally refer the patient to a dietitian or other relevant allied health or medical professional. They also reported that they would occasionally consult with another professional and move forward with a course of action. Support workers were, on the whole, acutely aware of the boundaries of their role, and reported that they would almost always refer to other staff in situations in which a clinical decision was required. Dietitians confirmed that a significant proportion of their patient referrals came from support workers, rather than from other members of the multidisciplinary team. Dietitians further suggested that it was crucial for support workers to understand, and adhere to, the scope of their role.

> *Ultimately they [allied health and medical staff] should be responsible for their patient – we just identify when somebody needs to be referred to the appropriate professional.*
>
> Dietary support worker

> *They [support workers] know their boundaries to be able to say to the patient 'hey listen you need to speak to the nurse about that'… [support workers] are very averse to putting themselves in the position where they make clinical decisions.*
>
> Stakeholder

There was significant disagreement amongst stakeholders as to whether or not the taking of patient meal orders constituted a clinical task. Stakeholders representing the dietetics workforce suggested that support workers would not be able to provide bedside nutritional support (including knowing when to refer to other professionals) without a significant amount of clinical nous, especially knowledge of therapeutic diets.

Yeah I think it's about the knowledge of the therapeutic diets and being able to, as I say it's then picking up on cues from patients, like if they don't choose much, giving them the encouragement, knowing what else they can offer, that relationship and communication with the patient as well as I think, obviously during malnutrition and screening and reporting that back.

Stakeholder

Stakeholders representing food services, however, suggested that the increasing introduction of computerised dietary management packages has meant that there is very limited scope to influence clinical outcomes at the bedside, as printed menus, on the whole, only contain foods and fluids that the patient can safely consume.

Support workers who had been employed over an extended period of time acknowledged that the clinical element of taking patient meal orders had been reduced since the introduction of computerised dietary management packages; however, most were also quick to stress that these packages were not yet perfect, and choices made available to patients often had to be checked. Most commonly, support workers cited occasions when patients on very restrictive diets were given a menu or tray containing very limited, or even no, options. Intervention and checking was also frequently required due to data entry errors (e.g. diet code entered incorrectly), and when patients were placed on restrictive diets for an extended period of time (e.g. nil by mouth for several days).

So it comes across when you're doing the menu you realise that there's been an error. So you try and fix that in-between seeing patients while discussing it with the nurse to double check that it's true.

Dietary support worker

Other commonly cited examples of the direct patient care provided by dietary support workers included:

- therapy under the direction of a dietitian (especially formal malnutrition screening)
- mixing and auditing enteral feeds
- mixing and auditing supplements.

It should, however, be noted that much of this patient care appears to be provided on an ad hoc basis while support workers are taking patient meal orders.

Dietary support workers who completed the online questionnaire were asked to indicate how often they performed a selection of clinical tasks. Table 12 shows the proportion of respondents who indicated that they complete each task at least once per shift. These results confirm that support workers regularly monitor patients to ensure that clinical diet protocols are being followed, and assess whether there are any patients at nutrition or hydration risk. Indeed, it appears that the large majority of dietary support workers regularly perform clinical tasks – even though they may not *define them as clinical* – over the course of a typical shift.

TABLE 12 – CLINICAL TASKS PERFORMED BY SURVEY RESPONDENTS

CLINICAL TASKS	PROPORTION WHO COMPLETE THIS TASK MORE THAN ONCE PER SHIFT
Communicate with all necessary other health service personnel regarding patient therapeutic diet requirements	82%
Facilitate and monitor food orders to patient food services	80%
Apply clinical nutrition/therapeutic diet protocols as delegated	80%
Identify and report factors that place patients at nutritional and hydration risk (e.g. low appetite, nausea, poor fitting dentures, frailty, etc.)	78%
Support the provision of basic nutrition advice/education	64%
Assist with dietetic program as directed by the supervising clinical dietitian	63%
Assist with nutritional support for patients with dysphagia	59%
Manage and coordinate the ordering of enteral feeds, commercial oral supplements and infant feeding formulas	57%
Facilitate access to food and fluids (e.g. opening packs, feeding patients etc.)	54%
Participate in risk screening including malnutrition screening and other relevant screening programs	54%
Assist the clinical dietitian with implementation and monitoring of prescribed nutrition care plans, including discharge planning	53%

DELEGATED INDIRECT PATIENT CARE

Indirect patient care tasks pertain to activities that are indirectly undertaken in a therapeutic capacity but would not normally form part of a care plan. Examples from the literature include preparing and maintaining environments for clinical procedures, contacting and informing relatives, monitoring progress, and escorting patients. Dietitians commonly reported that support workers played a significant role in monitoring the progress of their patients, with many directly stating that their position required them to cover multiple wards (and sometimes multiple hospitals) and that they relied heavily on support workers to inform them when a patient's progress had stalled or regressed. Some dietitians went as far as to suggest that support workers were sometimes better placed to monitor progress, as they had commonly built up a rapport with the patients.

> *The diet aide is the person who will frequently say to me 'hey I'll just let you know when I left the meal for Mr so and so he jumped in to have his drink and he was coughing'. Or 'I noticed that Mrs so and so is really only eating half her meals, I'd just thought I'd let you know'.*
>
> Stakeholder

This point was also made by the support workers, who suggested that they both formally and informally monitor patient progress, especially when taking patient meal orders. For example, one support worker reported that they measure patients when dropping off menus, while several others reported that they visually assess patients (especially patients on restrictive diets) when picking up completed menus.

COMMUNICATION

Qualitative research participants generally agreed that dietary support workers commonly play a crucial role in ensuring that relevant information is conveyed from the dietetics department to food services and vice versa. Indeed, stakeholders across the board explicitly stated that dietary support workers are often the link between these two very different departments, as they are the only group who possess basic clinical nous and an understanding of food preparation and distribution. Dietitians were particularly quick to acknowledge that their own understanding of the kitchen was limited, and that they relied on their

support workers to ensure that their requests for patients could be realistically implemented. Food services staff similarly suggested that it is sometimes difficult for them to make contact with a dietitian, and that, in the first instance, they put all diet queries to support workers, who can follow-up with a dietitian, if necessary.

> *The line of communication has been established where what we can say because that's where we actually become the liaison in-between like we are under food services and with the dietitians we go the in-between, the link. So that line of communication should be open all the time.*
>
> Dietary support worker

It was also suggested by stakeholders that dietary support workers play a crucial role in facilitating communication across multidisciplinary teams. For example, a support worker may notice that a patient is having trouble swallowing, or suggest to the dietitian that they might involve a speech pathologist. A number of dietary support workers stated that being able to communicate with allied health and medical professionals is crucial to their role, suggesting that this type of communication is commonplace.

> *So the model I often use is that the blind man and the elephant. I don't know if you know the parable but we all think we know the patient. We all think we've got a bit of it but we only see what we see and it's only until we actually communicate with another and the diet aides are smack bang in the middle of that communication, formally and informally.*
>
> Stakeholder

> *Communication with the multi-disciplinary team as well. So they're more likely to contact the speech pathologist or some OT [Occupational Therapist] for example if there's an issue that comes up whilst they're chatting to the patient. I know in our LHD the speech pathologist uses the dietitian assistants quite a lot.*
>
> Stakeholder

ADMINISTRATION

Dietary support workers most commonly reported undertaking general administrative duties and data entry (e.g. entering data into computerised dietary management packages). This was supported by the results of the quantitative research, with around 7 in 10 respondents indicating that they performed the following administrative duties at least once per shift: word processing, telephone duties, photocopying, monitor resource usage, laminating. A comparable result for other non-clinical tasks is shown in the table below. Survey respondents commonly reported checking the trayline (30%) and plating meals (23%); however it appears that office administration is undertaken more commonly than food preparation and distribution (see Table 13).

It should be noted that a few stakeholders suggested that they did not willingly assign administrative tasks beyond diet entry to support workers, as they felt that they tasks should be handled by hospital administration staff. In some circumstances, however, these administrative resources were not available, and support workers were their only option. In other circumstances, dietitians would personally undertake the administrative tasks themselves when assistants were not an available resource.

TABLE 13 – NON-CLINICAL PERFORMED BY SURVEY RESPONDENTS

NON-CLINICAL TASKS	PROPORTION WHO COMPLETE THIS TASK MORE THAN ONCE PER SHIFT
Administrative duties – word processing, telephone duties, photocopying, monitor resource usage, laminating	72%
Check trayline	42%
Collect data for monitoring, quality improvement or statistical purposes	30%
Plate meals	23%
Wash dishes (e.g. pack dishwasher)	16%
Collect meal trays from patients	14%
Assist with ordering and/or purchasing of supplies and materials including stationary, stock and non–stock items	10%
Assist in the identifying and ordering of equipment and resources as delegated by your supervisor	9%
Book appointments	3%
Participate in LHD performance management processes (e.g. performance appraisal)	1%
Deliver meal trays to patients	1%

EDUCATION

Dietary support workers occasionally reported playing a role in educating patients and family members about basic and more complex nutrition. This education was typically conducted informally at the patient's bedside; sometimes while taking a meal order. Dietary support workers most commonly indicated that they take on this role when a patient has been newly diagnosed with a condition that requires a restrictive diet (e.g. diabetes). In one location this education support role has been formalised, and assigned to one support worker.

> *We have a one-off position which is funded by donated funds – a nutrition education assistant position, which is like a sort of upgraded diet aide position, where we're [clinical dietitians] training an individual to teach patients directly one-on-one cooking skills and following medical diets and things like that.*
>
> Stakeholder

2.4 CONCLUSIONS

The evidence outlined in this chapter suggests that dietary support workers in NSW work across the following domains: delegated direct patient care, delegated indirect patient care, communication, administration, and education. The following chapter will consider the personal and contextual factors which drive variation in support worker roles.

3 Personal and contextual influences on the role of dietary support worker

3.1 KEY POINTS

Roles and responsibilities of dietary support workers are influenced by:

- **employer and supervisor:** Dietary support workers employed and managed through HealthShare NSW play a less sizeable (although not non-existent) and less defined role in delegated patient care.
- **location, staffing, and infrastructure:** Dietary support workers working in regional hospitals and in facilities without computerised dietary management packages typically have an expanded clinical role when compared to other support workers.
- **training, experience and personal attributes:** Delegation to support workers is a complex and multifaceted process that depends crucially on the dietitian's (or other manager's) assessment or judgement of the support worker's current education, experience, and competency.

3.2 EMPLOYER AND SUPERVISOR

The following key models for the employment and supervision of dietary support workers across NSW were reported:[6]

TABLE 14 – WORKFORCE MODELS

	EMPLOYER	MANAGERIAL SUPERVISOR	REGULAR CONTACT WITH DIETITIAN	OFFICE LOCATION
Workforce model 1	LHD or Speciality Network	Clinical Dietitian	Yes	Nutrition and Dietetics Department
Workforce model 2	HealthShare NSW	Food Services Manager	Yes	Food Services
Workforce model 3	HealthShare NSW	Food Services Manager	No	Food Services

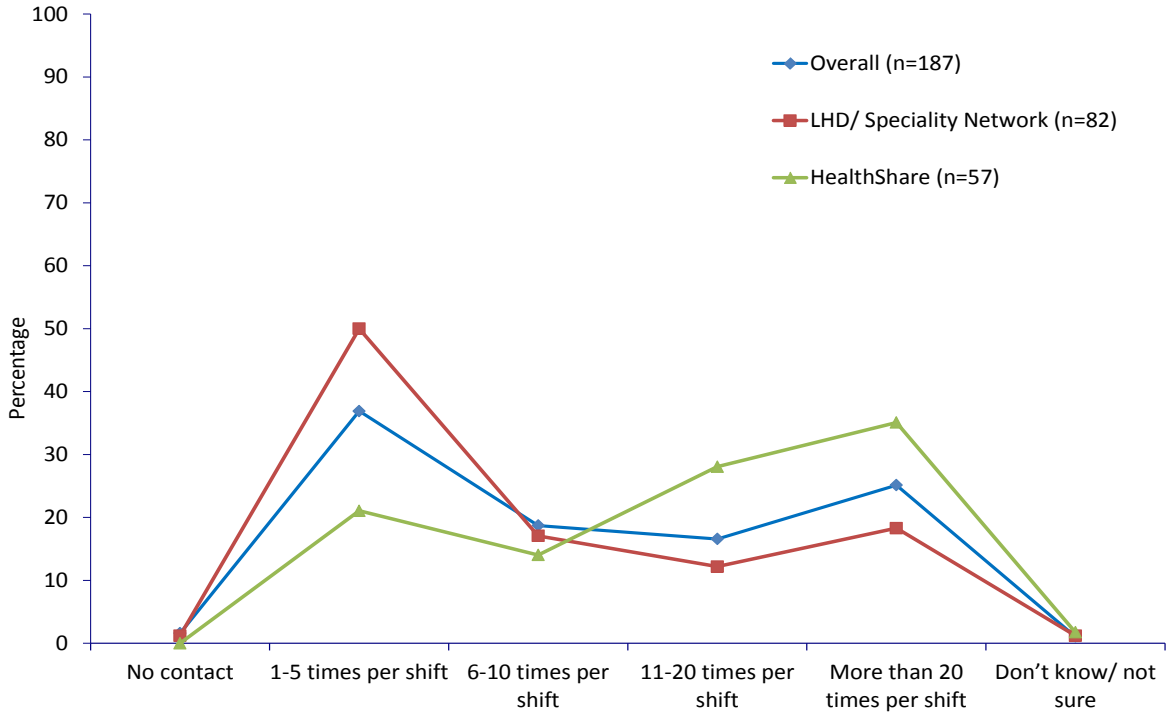
The extent to which (and even whether) a dietary support worker plays a direct, formal role in delegated patient care appears to be heavily influenced by the workforce model under which they are employed. Most notably, it was consistently reported that as the amount of direct contact with a clinical dietitian increases, so too does the amount of clinical tasks completed by the support worker. Support workers whose employment arrangements allowed for direct supervision by and ongoing contact with a clinician (i.e. workforce model 1) were the most likely to directly report performing clinical tasks. In contrast, support workers who were employed under HealthShare NSW and had no regular contact with a clinician were least likely to directly report performing clinical tasks. This is supported by the results of the quantitative research with support workers: on average, survey respondents employed by an LHD/ Speciality Network indicated that they typically spent 72% of their shift undertaking clinical tasks, compared to 28% for respondents employed by HealthShare.

> *Support workers under the supervision of the clinical dietitian have a delegation component [to their role]… But my understanding with nutrition assistants or diet aides they're under food services, they're not in a delegated relationship.*
>
> Stakeholder

[6] Note that other models of employment and supervision were reported; however, these were only mentioned by a small number, sometimes only one, of research participants. The vast majority of research participants fall within the three workforce models described here.

Support workers employed by HealthShare NSW were, not surprisingly, more likely to report being involved in meal production and distribution, and had increased contact with the kitchen. For example, survey respondents employed by HealthShare NSW were significantly more likely than respondents employed by LHD/ Speciality Networks to indicate that they had contact with patient food services more than 20 times per shift (35% compared to 18%, respectively; see Figure 2, below). That said, staff employed by an LHD/ Speciality Network still reported having regular contact with patient food services, with almost no respondents (n=3) reporting that they did not have any contact with patient food services during a typical shift.

FIGURE 2 – CONTACT WITH FOOD SERVICES BY EMPLOYER



Question: How often do you communicate with staff from Patient Food Services during a typical shift?
Base: Overall = 187; LHD/ Speciality Network = 82; HealthShare = 57

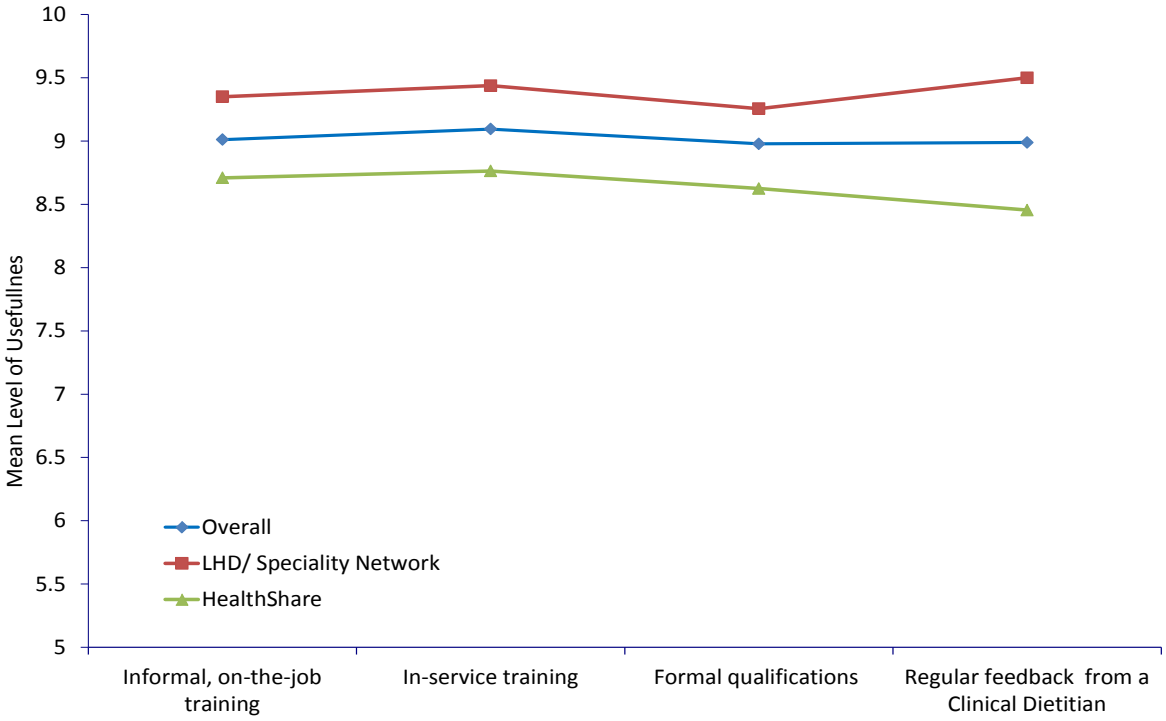
Support workers who had a close working relationship with clinicians suggested that their capacity to perform clinical tasks was substantially enhanced by the informal and occasionally formal supervision afforded to them via this relationship. Co-location of dietitians and support workers within hospitals was repeatedly cited as crucial to the transfer of clinical skills and knowledge, including understanding when and why to refer patients to an allied health, nursing, or medical professional. Support workers who were closely aligned with food services, in contrast, suggested that this alignment helped to ensure more streamlined (and less error-prone) processes for the meal ordering, production (i.e. tray line), and provision. These support workers did, however, acknowledge that the process-driven kitchen environment promoted a more transactional relationship with clinicians (i.e. procedural rather than clinical discussions). Communication between support workers located in food services and dietitians was reported to be especially difficult when working days or shifts did not perfectly align.

> *We have a dietitian we can ask questions but as you said you're sitting in a room with them and so you're hearing stuff so you're learning where we probably, unless we went and done a course or something like that we have certain knowledge but not a lot of knowledge, that's how I feel but you working with a dietitian in there, overhearing things you learn.*
>
> Dietary support worker

> *Well we have informal training with the dietitians and every time there's a new diet we get information about what it means and what foods they can eat and what affects and how they are affected.*
>
> Dietary support worker

Support workers who completed the online survey were asked to indicate, on a scale from 0 to 10, how useful a series of training opportunities were to the successful performance on their role. As shown in Figure 3, survey respondents employed through an LHD were significantly more likely to indicate that regular feedback from a clinical dietitian was useful. It should, however, be noted that this feedback was also highly valued by support workers employed through HealthShare.

FIGURE 3 – USEFULNESS OF TRAINING BY EMPLOYER



Question: Thinking about the skills required to perform your current role successfully, how useful is…?
Base: Overall = 176-184; LHD/ Speciality Network = 80-82; HealthShare = 55-56

Stakeholder who had an overarching view of the workforce more broadly confirmed that the performance of clinical tasks was strongly influenced by whether the support worker was employed within patient food services or the nutrition and dietetics department, and noted that in some cases the variance in responsibility had been formalised:

> *We have nutrition assistants that sit under food services and are managed by food services and we have dietitian assistants that are managed under nutrition and they have different responsibilities. So the dietitian assistants have a relationship with the dietitian and care for the therapeutic diet patients and the nutrition assistants care for the non-therapeutics and have no relationship with the dietitian.*
>
> Stakeholder

It should, however, be noted that there was evidence to suggest that the variance between dietary support workers employed by a LHD/ Speciality Network may sometimes lie in the way they *define tasks,* rather than in the actual tasks performed. For example, workers employed under a LHD/ Speciality Network felt encouraging a patient on a full-diet to eat a healthy dinner was a clinical task while support workers employed by patient food services defined this as a procedural task. In addition, it appears that many of the tasks that support workers define as clinical are sometimes performed by food services staff with limited training, especially in smaller hospitals.

> *If I do a food service assistant shift, I have to deliver trays, collect trays, meet meal service, if I work in the diet office I have to go through all the menus and check all the diets according to the diet codes if there is any mistakes I have to ring diet aides and let them know to fix it.*
>
> *Food services staff*

That said, dietary support workers with clinical training and stakeholders were keen to point out that when they provided advice to patients, they draw upon their extensive therapeutic knowledge and experience. This means, for example, they are able to make recommendations regarding the healthiest combination of foods and fluids, given the patient's condition, and answer questions about a therapeutic diet.

> *The delivery of therapeutic diets is part of a dietitian's clinical therapy. Thus it is really important that the staff member handing out the menu has good knowledge of the menu being provided to be able to assist the patient in their therapeutic food choices, as the patients do ask a lot of questions.*
>
> Stakeholder

3.3 LOCATION, STAFFING AND INFRASTRUCTURE (INCLUDING TECHNOLOGY)

The roles and responsibilities of dietary support workers was influenced – although to a lesser extent than employer and supervisor – by the location, staffing, and infrastructure of the hospital or hospitals in which they worked. This is not surprising as these factors tend to heavily influence the delivery of most health services.

Dietary support workers working in regional hospitals were typically given more clinical responsibility and independence than those working in metropolitan hospitals. Dietitians working in regional areas noted that they had a large area to cover, and would often go for days or even weeks between visiting sites. In their absence, these dietitians reported that they relied heavily on clinically competent support workers to monitor patients, and even perform simple therapeutic procedures, if required. Regionally located support workers also stressed that they could go for a substantial length of time without meeting face-to-face with a clinical dietitian, even if that dietitian was their supervisor.

> *I saw [Bryce] yesterday, but before that I hadn't seen him for probably a month; he's not always there the days I work.*
>
> Dietary support worker

Dietitians and other allied health stakeholders noted that clinically competent support workers were a crucial part of the regional health workforce. These stakeholders, however, further noted that because of their expanded clinical role, it was important for support workers in regional locations to be highly-trained and formally supervised, where possible. In particular, it was suggested that support workers who regularly undertake delegated patient care, but do not have daily contact with a dietitian, should, at minimum, possess a Certificate IV in Allied Health Assistance; a Certificate III was considered appropriate for support workers who have daily contact with a clinical dietitian.

There were a few examples of facilities (e.g. mental health facilities; small regional hospitals) in which computerised dietary management packages had yet to be adopted. Dietitians and support workers employed in these facilities noted that it was crucial for the staff member responsible for taking patient meal orders (dietary support worker or otherwise), and checking meals, possess extensive knowledge of all therapeutic diets, as the entering of patient diets (and subsequent meal options made available) was not automated.

The scope of practice for dietary support workers can vary from hospital to hospital (and even day to day) depending on the unique combination of staff on site. For example, support workers commonly reported that kitchen staff sometimes pushed them to make clinical decisions when there were no dietitians on site (e.g. on weekends). Some support workers admitted making changes to a patient's diet – a task outside of their scope of practice – on occasions when they knew a patient would have to wait for an extended period before seeing a dietitian.

> *Sometimes I do override the system and that and you know I know it's not going to cause any damage, it might just be a different type of sandwich or something different that's on but I think once you've been there for long enough you sort of know the scope, there's over the line and there's yeah. I'd never do anything that was going to you know…*
>
> Dietary support worker

In addition, food service staff reported taking on an extended role (e.g. some form of hospital support worker) on occasions when dietary support workers were not on site. For example, on weekends food services staff may take on responsibility for checking therapeutic diets.

3.4 TRAINING, EXPERIENCE AND PERSONAL ATTRIBUTES

The dietary support worker role has not, to date, been subject to statutory regulation or formal training requirements, and the level and type of training reported by support workers varied from no formal training at all to an undergraduate dietetics degree from an overseas university. Stakeholders consistently suggested that the regulation and formalisation of qualifications may assist with the development of a defined scope of practice and model job description. As it stands, the roles and responsibilities of support workers vary significantly depending on education, and also depending on skills acquired during on-the-job experience.

Dietary support workers who had attained formal catering and food preparation qualifications, and perhaps experience working as a cook, reported spending a significant amount of time in the kitchen (e.g. working on and checking the tray line, assisting with food preparation), especially if they were managed by food services. In contrast, dietary support workers who had attained formal nutrition qualifications were likely to view their role as clinical, and to cite examples of ways in which they had attempted to enhance the number of therapeutic tasks performed during a typical shift. These support workers commonly had limited contact with food services, and sometimes stated that they had never been in, or even near, the hospital kitchen.

Support workers with nutrition qualifications sometimes reported that they were frustrated by the poor alignment between their current role and the knowledge and skills they had acquired through their studies. Support workers who expressed an interest in nutrition and patient welfare occasionally reported tailoring tasks so that they could utilise their clinical expertise – for example, ensuring that patients on a full diet were eating in a way that would benefit their nutritional and therapeutic outcomes.

> *I went to uni and I did nutrition and dietetics and this is nothing like what I studied. Like we learned about malnutrition, we learned about all about the different diseases and issues that come around but I'm not allowed to use any of that information at the hospital. I just have to kind of do what they tell me to do.*
>
> Dietary support worker

> *But for example like with diabetics, I sort of encourage them to have instead of juice have water, things like that.*
>
> Dietary support worker

It was, however, suggested that support workers who simultaneously possessed a formal nutrition qualification (in rare instances, a dietetics degree) and a passion for patient welfare could sometimes push the boundaries of their role. Indeed, diet managers and dietitians alike suggested that monitoring high-qualified, passionate support workers could sometimes be challenging.

> *We did get a lot of overseas qualified dietitians and then not qualified here and they haven't done the exam and then it's very much just crossing the line of how much they can say and how much power they have...*
>
> Dietary support worker

There is also evidence to suggest that the support worker role is largely defined by the tasks allocated to them by the qualified staff who they support (e.g. clinical dietitians). Some dietitians, especially those in regional areas, reported that they were happy to delegate clinical tasks to support workers who possessed a Certificate IV in Allied Health Assistance, while others felt that all clinical decisions should be made by a fully qualified allied health professional. The delegation to support workers appears to be a complex and multifaceted decision that depends crucially on the dietitian's (or other manager's) assessment or judgement of the support worker's current education, experience, and competency (i.e. role scope may be influenced by the level of confidence that a dietitian has in a support worker).

The delivery of therapeutic diets is part of a dietitian's clinical therapy. Thus, I think it is really important that the staff member handing out the menu has good knowledge of the menu being provided to be able to assist the patient in their therapeutic food choices.

Stakeholder

3.5 CONCLUSIONS

Role and responsibilities of dietary support worker across NSW are strongly influenced by employer and supervisor, with support workers employed and managed through HealthShare NSW playing a less sizeable (although not non-existent) and less defined role in delegated patient care. The following chapter will consider the impact of proposed service delivery reforms on the procedures for nutrition risk assessment.

4 Impact of proposed service delivery reforms on procedures for nutrition risk assessment

4.1 KEY POINTS

- Nutrition risk assessment can be performed informally by dietary support workers when they are taking patient meal orders, or at other times in which they have direct contact with patients.
- Under the proposed service delivery reforms, dietetic staff (i.e. support workers supervised by clinical dietitians) may not be responsible for taking patient meal orders.
- There is disagreement about whether taking patient meal orders is crucial to the conduct of nutrition risk assessment.
  - Dietetic staff typically argued that the process of taking meal orders was crucial to informal nutrition risk assessment, as it allowed support workers to build rapport and, importantly, make a clinical assessment of patients.
  - Food services staff typically argued that dietary support workers could provide this service (i.e. malnutrition screening) without taking on responsibility for patient meal orders.
- Frontline food services staff and dietetics staff alike were not convinced that all food services staff currently possess the knowledge, skills, training, or basic competences to perform informal nutrition risk assessment.

4.2 CURRENT PROCESSES FOR NUTRITION RISK ASSESSMENT

Taken together, the findings from dietetic staff (including dietitians and support workers) outlined thus far suggest that nutrition risk assessment can be performed informally by dietary support workers when they are taking patient meal orders, or at other times in which they have direct contact with patients. In some hospitals, dietary support workers are only responsible for taking meal orders from patients who have been placed on a therapeutic diet, while in other hospitals they are responsible for taking all patient meal orders. There are also examples in which support workers play no role in taking patient meal orders (i.e. the hospital does not employ support workers).

Dietary support workers may also undertake or assist with formal malnutrition screening or assessment (including via the MST), which is occasionally completed while taking patient meal orders. Informal assessments (and monitoring) are more likely to be carried out by support workers who possess formal nutrition qualifications, are employed by an LHD, and supervised by a clinical dietitian. Most often, patients who are informally assessed to be at risk of malnutrition or dehydration are referred to a clinical dietitian or another allied health, nursing, or medical professional (e.g. speech pathologist, nurse, and so on). Through this process, dietary support workers sometimes also monitor adherence to therapeutic diets. Drawing upon the Nutrition Care Policy (NSW Health, 2011), definitions of informal nutrition risk assessment, formal nutrition assessment, and formal nutrition screening have been provided in Box 1. As the evidence suggests that dietary support workers most commonly perform, or assist with, informal nutrition risk assessment while taking patient meal orders, the remainder of this chapter will be devoted to considering the impact that the proposed service delivery reforms could have on procedures for informal nutrition risk assessment.

BOX 1 – NUTRITION RISK ASSESSMENT – KEY DEFINITIONS

Informal nutrition risk assessment: Informal questioning and observation during direct patient interaction that helps identify barriers to nutrition intake in order to initiate corrective action(s) (e.g. consideration of dexterity, vision, hearing, comprehension, literacy, nutrition knowledge, dentition etc.).

Formal nutrition assessment: A comprehensive process to define a person's nutritional status, identify nutrition-related problems and help determine appropriate mitigation actions. Formal nutrition assessment must be carried out by a dietitian.

Formal nutrition screening: The use of a validated tool to determine if a patient is at nutritional risk (e.g. Malnutrition Screening Tool, Malnutrition Universal Screening Tool, Mini Nutritional Assessment). Nutrition screening is a rapid, simple and general procedure that can be carried out by nursing, medical or other clinical staff.

NSW Health 2011 *Nutrition Care Policy* Accessed 26 August 2015 available at http://www0.health.nsw.gov.au/policies/pd/2011/pdf/PD2011_078.pdf

4.3 IMPACT OF PROPOSED SERVICE DELIVERY REFORMS

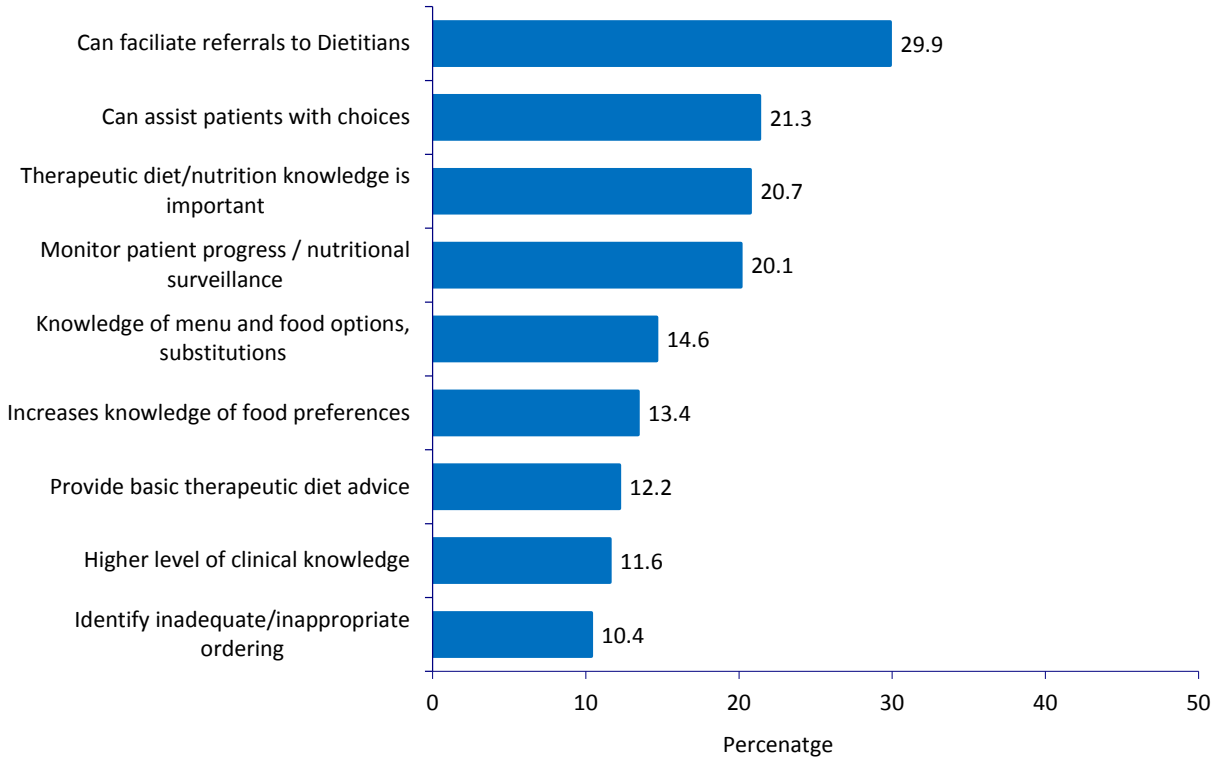
Under the proposed service delivery reforms, food services staff, not dietary. support workers supervised by clinical dietitians, may be responsible for taking patient meal orders, using electronic hand-held tablets that are directly linked to computerised diet management packages and to patient food services information systems. The use of tablets for taking patient meal orders was almost universally supported, with most agreeing that the technology could potentially decrease the amount of time taken to complete the task and reduce errors.

However, the majority of the dietetic staff who were consulted for this project (including dietitians and support workers employed by an LHD/ Speciality Network) were adamant that the informal nutrition risk assessment that dietetic staff undertake when taking patient meal orders was a therapeutic task that could contribute crucially to positive nutritional, and sometimes clinical, outcomes for patients, regardless of whether patients were on a full or therapeutic diet. In support of this view, dietetics staff were keen to point out that meal consumption (or lack thereof) could be a crucial early indicator of patient deterioration. Staff were also keen to note that a patient's nutritional status could quickly deteriorate, and regular monitoring by suitably qualified staff could prevent malnourishment from reaching a clinical level. In addition, dietitians who completed the online questionnaire commonly reported that support workers should be responsible for taking patient meal orders as the task provided these workers with an opportunity for monitoring and surveillance (see Figure 4, overleaf).

> *But also we have that one-on-one with the patients as well and that's really really important. Because we're like the frontline to the dietitians. So we'll be like this patient doesn't like this and doesn't like that and we can fix all of that up and we can go back to the dietitian and talk to them about whatever the other patient brought up and it's really important, it really is.*
>
> Dietary support worker

> *I think food is sort of on the bottom of the chain when they come to hospitals sometimes that the nursing staff is so busy taking care of the patients' well-being that they forget that food is one of the most important things. If the patient is feeling sick and sort of ill, food is one of the things they're probably going to complain about…*
>
> Stakeholder

FIGURE 4 – REASONS DIETARY SUPPORT WORKERS SHOULD BE RESPONSIBLE FOR TAKING PATIENT MEAL ORDERS



Question: Why do you think that nutrition and dietary support workers should be responsible for taking patient meal orders?

Base: 164

Food services staff, in contrast, typically reported that dietary support workers could provide this service (i.e. malnutrition screening) without taking on responsibility for patient meal orders. From their view, taking patient meal orders, especially with the assistance of computerised diet management packages, was a purely procedural task, and enhancing links between patient meal ordering and food services would assist in streamlining meal production and distribution. For example, complaints about an incorrect or late meal would always go to staff with close ties to, or even responsibility for, meal production.

> *There's no reason why food services couldn't do everything to be honest because CBORD is there and the system is not going to allow you to give the patient something that is not compliant to their diet so even though they take care of all the clinical patients there's no reason why food services couldn't do that because the dietitian could go in and she could put someone on a mince diet and it's not going to allow her to give something un-minced, the system just won't allow it.*
>
> *Food services staff*

Frontline food services staff and dietetics staff alike were not convinced that all food services staff currently possess the knowledge, skills, training, or basic competences to perform informal nutrition risk assessment. Dietetic staff were also keen to point out that computerised diet management packages are imperfect, and that a trained nutrition professional is required to ensure that patient risk is mitigated.

Dietitians were also concerned that the link between the person responsible for taking patient meal orders and the nutrition and dietetics department was weakened under this model, increasing the potential for errors in communication and diminishing the clinical role of dietary support workers.

> *Our food services systems wouldn't have any clue about compliances and foods too and probably would then go up and go on yeah this thick and fluid person wants ice cream.*
>
> Dietary support worker

Upon consideration, dietetic staff sometimes acknowledged that the process for taking patient meal orders (especially for patients on non-therapeutic diets) could be procedural and time-consuming, and

sometimes meant that dietary support workers with clinical training and experience were not able to utilise their skills. These staff felt that while it was crucial for members of the dietetics team to have access to information about patient meal consumption (especially when related to therapeutic diets), this could perhaps be accessed via computerised diet management packages. Support workers could then directly follow up with patients, and refer to other allied health and medical professionals, if deemed necessary.

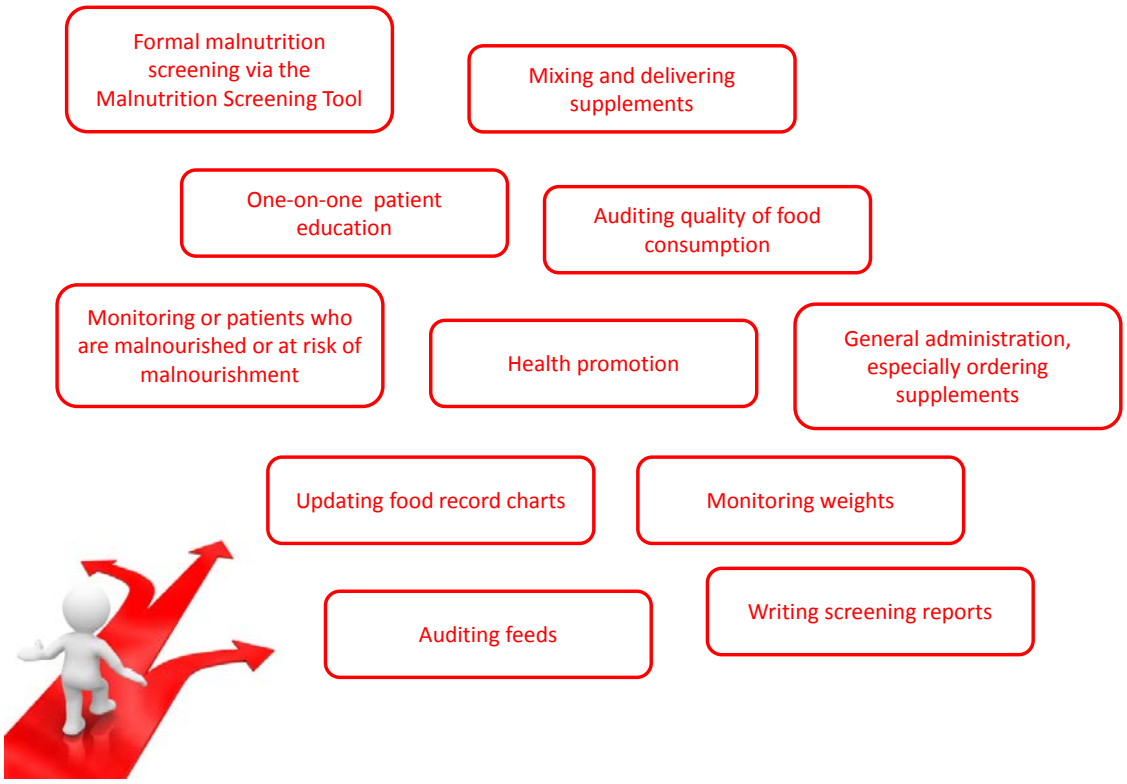
> *[If we were not responsible for taking patient meal orders] we'd have more time to spend with the patients because we're always on the run, we've got to have this done by this time, this done by this time so some corners will get cut as far as spending time with patients and if they're really demented and you know they'll get a default meal because you've got to have everything done by a certain time…*
>
> Dietary support worker

Most dietetic staff, however, felt that the actual process of taking meal orders was crucial to informal nutrition risk assessment, as it allowed support workers to build rapport and, importantly, make a clinical assessment of patients.

> *So for me that task and the core aspects of good service and good therapeutic nutrition care start with that menu completion task.*
>
> Stakeholder

Dietetic staff suggested that if support workers with clinical training were not responsible for taking patient meal orders, they may be able to play an enhanced role in the following domains:

FIGURE 5 – POTENTIAL DOMAINS OF DIETARY SUPPORT WORKERS



As outlined under Section 1.2.1 of the literature review (see Appendix A), dietary support workers in other jurisdictions (i.e. US and UK) play significant roles in these domains, especially if the support workers are not responsible for taking patient meal orders. The table below summarises the reported advantages and disadvantages of having patient food services' staff and nutrition and dietetic department staff responsible for taking patient meal orders. The table was developed using the qualitative data collected from food services staff, dietary support workers, and stakeholders.

TABLE 15 – RESPONSIBILITY FOR PATIENT MEAL ORDERS – ADVANTAGES AND DISADVANTAGES

FOOD SERVICES		DIETETICS DEPARTMENT	
Advantages	**Disadvantages**	**Advantages**	**Disadvantages**
Food Services has control over processing requests.	Clinical information not recognised or lost.	Clinical information remains within clinical domain.	Some parts of role time and tasks driven by Food Services
Potential for staff to be involved with process from order to delivery	Inability of dietitian to delegate.	Develop rapport with patients through all tasks.	Take time away from other clinical tasks.
Potential higher awareness of service stock and management.	Increased delay from observation of risk to intervention	Nutrition care of patient is focus.	
Increased staff satisfaction through patient engagement and connection between patient and food preparation.	Staff may not be aware of nutrition goals.	Integrated nutrition care process.	
	Multiple people communicating with same patient.	Patient queries efficiently addressed or directed.	
		Staff aware of patient nutrition goals.	
		Source of clinical referral.	
		Opportunity for informal nutrition screening.	

4.4 CONCLUSIONS

There is disagreement about whether taking patient meal orders is crucial to the conduct of nutrition risk assessment. Dietetic staff typically argued that the process of taking meal orders was crucial to informal nutrition risk assessment, as it allowed support workers to build rapport and, importantly, make a clinical assessment of patients. In contrast, food services staff typically argued that dietary support workers could provide this service (i.e. malnutrition screening) without taking on responsibility for patient meal orders. These arguments are discussed further in the following chapter, conclusions and recommendations.

5 Conclusion and recommendations

This project has sought to understand the dietary support workforce across NSW: their roles and responsibilities, line management, education, and demographics. In the course of doing so, the review team has met with dozens of dietitians, food services staff, managers, and people working in roles with the titles of diet aide, dietitian assistant, nutrition assistant, and allied health assistant.

As noted earlier, one of the drivers for this project is the proposed change in food delivery services currently being trialled at the Mona Vale Hospital. The main impetus for this proposed change is to improve the efficiency and quality of food service delivery through streamlined processes supported by innovative technology. One of the implications of this new delivery model for dietitians is that the taking of menu orders may be undertaken by food services staff working to a very structured menu choice algorithm.

5.1 FOOD AS THERAPY OR HOSPITALITY

> *…it's about the clinician that's kind of got a foot in both camps it's got the clinical but it's also got the food service element. If you skewed it one side or the other and the fact is it actually is required across elements of both.*
>
> Stakeholder

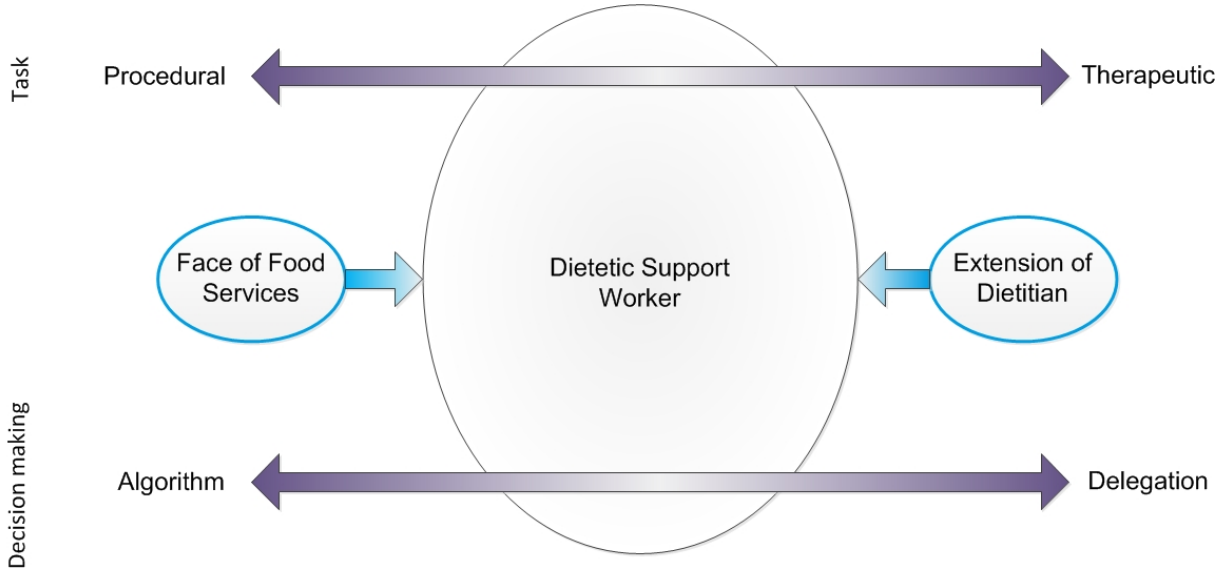
Fundamentally, a key question to be answered in determining food service delivery models is whether food is considered a treatment modality or a housekeeping matter, part of the hospitality offered to a patient during their stay in hospital. The values of the latter view will be expressed as quality of food presentation, customer service, consumer choice, and patient satisfaction with the product. The values of the former will be expressed as nutritional therapy, assessment of clinical risk, monitoring patient wellbeing, and achieving nutritional goals. It should however, be noted that these two paradigms are not discreet: appealing presentation, good customer service and so on can influence clinical outcomes for patients (for example, through increased food consumption). Equally, a patient's perceptions of hospitality can be influenced by their experience of the clinical care they receive.

Most of those consulted would agree that food service in a hospital is both treatment and hospitality. There are essential roles for both food services and for dietetics departments in food planning, preparation and delivery. These have developed over time and are organised differently in different locations depending on the needs and resources of the local environment.

The research has identified that dietary support workers, however named, undertake a wide range of tasks, and that 80% of them undertake clinical tasks more than once each shift. Conversely, a very small percentage of support workers are directly involved in the delivery of meals, collecting of meal trays, and associated tasks. From this it appears that a large component of the dietary support workers' time is spent on tasks defined as direct patient care. It should be noted that this includes the taking of meal orders, which is viewed by dietitians as a clinical task, but is viewed by most food services respondents as a food delivery task.

The two primary factors that distinguish roles, according to research participants, are the extent to which a task is therapeutic or procedural, and the extent to which a person has delegated decision-making authority. The diagram below illustrates this spectrum of tasks and authority. Across these two domains there is a core scope of work generally conducted by most dietary support workers. There are also other tasks which relate more closely either to food service delivery, or dietetic therapy, depending on the line management and location of the individual staff member.

FIGURE 6 – FACTORS INFLUENCING DIETARY SUPPORT WORKER RESPONSIBILITIES



Those stakeholders who favoured a greater role by food services staff in meal ordering considered that this allowed kitchen staff to be more visible to patients and to have direct engagement in all aspects of the delivery chain from meal preparation to delivery and customer satisfaction. This is the hospitality paradigm of food.

Those stakeholders who favoured limiting meal taking to dietary support workers under the delegation of a dietitian considered that meal taking is a therapeutic task allowing a clinician (the dietitian as represented by the dietary support worker) to assess the nutritional wellbeing of the patient, to identify any risks, to consider any clinical or treatment changes, and to ensure that the menu provides for the patient's health needs. This is the therapeutic paradigm of food.

Whether a dietary support worker is located within a dietetics department or within food services is influenced not only by one of these paradigms, but by larger structural decisions that are often made for strategic and financial reasons unrelated to food. In addition, the resource requirements available to a large metropolitan teaching hospital or to a small rural hospital will influence the ways in which diets are planned, prepared, delivered and assessed.

To a large extent, the current variety in models of therapeutic dietetic activities and food delivery processes has evolved organically across the state in response to local history, service demand, and structural capacity. This has contributed to the lack of consistency and some confusion regarding the use of various titles, employment awards, and differences in educational qualifications, across dietary support workers. Organisational restructures and changes over time have also meant that some staff previously employed under one department may now be working in another, sometimes maintaining a previous scope of practice wider than their current job description might allow.

At the same time, one of the key attributes of the support worker position has been identified as the flexibility to undertake a wide range of activities across the spectrum between food services and clinical nutrition. Stakeholders strongly advocated for the role's contribution as a bridge between the therapeutic and the procedural activities associated with food preparation and consumption. The role of dietary support worker confirms that food is both therapy and hospitality, demonstrating the need for clinical and logistical services to work closely together to meet the nutritional needs of patients. Put simply, the dietary support worker provides an essential liaison function not currently played by any other role.

While maintaining this flexibility of role to move across the spectrum as required, there are clear distinctions between those managed under a food services paradigm and those managed under a therapeutic paradigm. This is primarily in the extent to which staff work on more administrative and procedural tasks, or engage more with the patient and with the multi-disciplinary clinical team. Dietary support workers who are managed by dietetics departments reportedly wear a clinical uniform distinguishing them as part of the clinical team, and are provided with opportunities for continuing professional development through participation in ward rounds, formal and informal discussions with

dietitians and other clinicians, and regular clinical supervision. Dietary support workers managed by food services often have no direct, or limited, contact with dietitians and focus primarily on the procedural aspects of food planning, preparation and delivery.

Given the larger, national trend towards the increased use of delegated roles such as allied health assistant roles, there will be value in defining the dietary support worker roles in NSW more clearly, and particularly in clarifying the nomenclature. Whether a support worker works within the paradigm of hospitality or therapy, there will be an overlap of certain tasks and activities; this could be more clearly aligned with a patient-centred approach that determines how each role contributes to the overall nutritional wellbeing of the patient.

An indicative table outlining some distinctions of roles, based on stakeholder consultation, is provided in the table below, recognising that there is role diversity across LHDs and that the resources will differ across hospital settings. This is not intended to be prescriptive or to suggest that these tasks are delivered in all cases by either role, but to suggest that further work might be able to provide a more consistent understanding of position titles and responsibilities.

Clarifying these roles will also assist in defining career pathways for some workers who may wish to progress to roles of greater responsibility over time.

TABLE 16 – ROLE DISTINCTIONS BY LINE OF MANAGEMENT

ROLE	DIETARY SUPPORT WORKERS MANAGED THROUGH FOOD SERVICES	DIETARY SUPPORT WORKERS MANAGED THROUGH DIETETICS DEPARTMENTS
Training	▪ On-the-job training ▪ Health Support Certificate III ▪ HealthShare course through Sunshine Coast to provide additional training	▪ On-the-job training ▪ Certificate III in Nutrition and Dietetic Assistance ▪ New version Certificate IV - with dietetic focus ▪ Cert IV Allied Health Assistance or equivalent experience ▪ Regular clinical supervision
Tasks	Characterised by procedural tasks without delegated therapeutic responsibilities, and little or no relation with dietetics departments Indicative tasks include: ▪ Food preparation and delivery tray line ▪ Processing late orders ▪ Provide food services after dietetics closed	Characterised by therapeutic work under the delegation of a qualified dietitian Indicative tasks include: ▪ Functions as an extension of dietitian relationship with patients ▪ Education with food services staff ▪ Patient education ▪ Patient weighing, screening and reviews ▪ Use of therapeutic knowledge in assisting patients with meal choices ▪ Clinical nutrition monitoring ▪ Liaison with other clinicians ▪ Ward rounds ▪ Quality improvement reporting ▪ Data entry ▪ Formula preparation/enteral feeds ▪ Health promotion
	Tray Lines	
	Prepping	Checking
	Menus	
	▪ Algorithm ▪ Limited role in assisting patient choice	▪ Monitoring ▪ Picking up cues – all patients in hospital ▪ Separating food preferences from diet requirements

Recommendation 1 Establish consistent job titles and job descriptions across the spectrum of dietary support worker roles.

5.2 OPENING THE INFORMATION LOOP

…in streamlining the food service loop we fracture the nutrition care loop.

Stakeholder

The proposed changes to food service delivery now being trialled at Mona Vale hospital have been introduced with the aims of increasing efficiency and reducing costs of food service preparation and delivery, reducing mistakes and waste (and thus patient complaints), and increasing patient satisfaction. There is also an objective of increasing role satisfaction and engagement for food preparation staff, by increasing their responsibility across the entire chain of food preparation from planning to delivery, including contact with patients to take meal orders.

Stakeholders have agreed that increasing the use of technology in meal ordering, particularly in the ability to reduce the time between ordering and receiving a meal, has the capacity to improve services immensely. It was also generally agreed that the innovative use of technology has the potential to free up workers taking patient meal orders to perform other tasks, clinical or otherwise. Many hospitals have already introduced some form of computerisation into the meal ordering process, and the trial at Mona Vale Hospital is being watched with great interest to identify the factors which are most effective in improving outcomes and reducing waste and costs.

Differences arise over a very specific aspect of the trial, which is the taking of patient meal orders. As noted above, much of this stems from the question of whether order taking is a therapeutic or a procedural task. Several questions thus arise:

- is meal ordering a clinical task?
- what would dietary support workers do with their time if not taking patient meal orders?
- is the new food service delivery model dependent upon food services staff taking meal orders, or could the new technology be implemented while dietary support workers retain the task of taking patient meal orders?

The latter question is out of scope for this project and cannot be answered by the data available to the research team. The first two questions are discussed in the sections below.

5.2.1 MEAL ORDERING AS CLINICAL TASK

The weight of evidence from this project suggests that taking meal orders is an opportunity for dietary support workers to undertake monitoring, observation, and informal nutrition education with patients. It is not the taking of a patient's meal order in itself that forms the clinical task; rather, this task provides a structured, regular face to face encounter with a patient which can allow the support worker to undertake an informal nutrition risk assessment of the patient, or the patient to voice a concern or complaint. This encounter also allows the support worker to respond immediately to issues that might arise regarding food consumption, including taste and texture, nausea and inability to take food, difficulties in swallowing, or other physical responses to food intake. It is not that the staff member needs to be trained and experienced in diet and nutrition in order to take the order itself, in terms of the functional activity of recording meal orders. The concern has been expressed that an untrained worker will not pick up the unspoken clues regarding malnutrition, dehydration, or changes in the physical condition which may warrant changes to the patient's diet, or further clinical assessment.

As noted above, research participants welcomed the increasing use of technology to increase the efficiency of meal ordering, and agreed that diminishing the period of time between ordering and serving a meal is likely to reduce waste and increase appropriateness. The real question is who should hold the wireless device and stand in front of the patient to take the order.

There are many reasons that have been given for delegating the meal ordering to food staff, including increasing staff satisfaction, linking meal ordering more closely to the food preparation chain, and increasing efficiency. No reasons related to the therapeutic benefits for patients have been given, confirming that the primary reason for the proposed changes to the service delivery model is a logistical one. At the same time, these changes could have significant impact on the ability of dietary support

workers to support patients. Stakeholders have also acknowledged a potential impact on the clinical risks associated with nutritional therapy, if dietary support workers are further removed from the task of meal ordering. Dietitians in particular are concerned to ensure that, if the changes are implemented more widely, clinical governance is clarified to maintain a clear line of responsibility for managing risk associated with food intake.

Stakeholders have discussed the alternatives for dietary support workers to monitor and assess patients at other times of the day, if not doing so through the meal ordering process. This is certainly possible; however, it would require scheduling assessment as a daily task (in the same way that meal ordering is scheduled) to ensure that the daily monitoring reportedly taking place during the meal order is not lost. It also raises the potential that the support worker will not see everyone; unlike a meal order which has a clear importance for the patient, patients may not see the benefit of spending time talking to an additional person about food-related matters at other times of the day, or they may be sleeping or occupied with other clinicians.

Two questions would need to be resolved, we suggest, for the proposed model to be implemented more widely. The first is the extent to which dietary support workers use the meal order to conduct clinical tasks, and how much time this takes; the second question is what kind of nutrition risk assessment and monitoring activity takes place at other times of the day.

Recommendation 2 Conduct a study across different hospital settings to audit nutrition risk assessment activity, to clarify the extent to which dietary support workers actually use the menu ordering task to conduct therapeutic activities, compared to the demands of completing the meal ordering rounds. This audit should also analyse monitoring and other risk assessment activities which take place at other times of the day. This audit could be used to clarify the best way to schedule monitoring activities, should dietary support workers not continue to take meal orders.

5.2.2 POTENTIAL RE-ALLOCATION OF ASSISTANT TASKS

What would dietary support workers do if they are not taking meal orders? Research participants had no trouble identifying the tasks which could be done by dietary support workers if they were not spending so much time on meal ordering. Some of these tasks, it should be said, are currently being undertaken during the meal ordering process, so they would simply continue to be done at other times of the day. The list below is not comprehensive but does identify a range of tasks which could be enhanced if time was freed from meal ordering:

- patient screening and reviews
- clinical risk assessments, use of MST, weighing patients
- formula preparation and preparation of enteral feeds
- health promotion and nutrition education
- quality improvement tasks
- reporting
- liaison with other clinicians regarding dietary matters (eg speech pathologists, nurses)
- attending ward rounds
- data entry.

Stakeholders considered that the use of the assistant workforce to improve task allocation through appropriate role delegation provides efficiencies and frees up the dietitian to undertake more complex clinical tasks. Dietitians also considered that there is immense value in having the dietary support worker take the meal order because this in itself provides an efficiency: the meal order has to be taken, and patients need to be assessed, so the support worker does both at the same time. Much of the informal

and formal feedback provided to dietitians by dietary support workers is gained through the conversations held during the meal order process.

In some locations, where there are no dietary support workers working under dietetics departments, dietitians themselves undertake tasks normally delegated to an assistant. Research participants noted that in this situation there is still an attempt to liaise across the two areas – food services and dietetics – however this is unwieldy and information is not easily shared simply due to the burdens of workload and the lack of a clear communication channel.

LHDs and the Ministry will need to consider how best information regarding food intake, any reported problems with consumption or diet choice, and a range of other important clinical information will be communicated to dietitians if support workers who are taking meal orders are not in direct reporting lines to dietitians. The importance of the dietary support worker as a liaison between the two departments is considered to be of such importance by dietitians that, if meal ordering is removed from their tasks, other opportunities will need to be found to ensure that the liaison continues to occur so that information flows freely across the continuum from meal ordering through consumption to nutrition monitoring.

Recommendation 3 Should the trial be expanded to other hospitals, the food services project team should work with dietitians and dietary support workers to design a job description which fully describes the wide range of alternative tasks, to ensure that the dietetic workforce remains fully deployed and that the staffing allocation is not lost from dietetics.

5.2.3 ADDITIONAL ACTION ITEMS

In addition to the three primary recommendations included above, the following action items for consideration have been developed using the research results:

Action item 1 Prior to implementation of the revised service delivery model, food services staff who will have a customer-facing role should, at a minimum, receive training in basic nutrition and customer service.

Action item 2 A formal clinical governance model (including managerial and clinical supervision) should be developed for dietary support workers. This model should be aligned with the NSW Ministry of Health Allied Health Assistant Framework, and should include clear lines of managerial and clinical supervision responsibilities for dietary support workers working within both food services and dietetics departments.

Appendix A Literature review

FIGURES:

TABLES:

TABLE 1 – LIST OF ACRONYMS

ACRONYM	EXPANSION
ADA	American Dietetic Association
AHA	Allied Health Assistant
AP	Assistant Practitioner
BDA	British Dietetic Association
CADE	Commission on Accreditation for Dietetics Education
CDR	Commission of Dietetic Registration
DAA	Dietitians Association of Australia
DSW	Dietetic Support Worker
DTR	Dietetic Technician (registered)
NCP	Nutrition Care Process
NHS	National Health Service
NSW	New South Wales
UK	United Kingdom
US	United States

1 Literature review

1.1 BACKGROUND

1.1.1 INTERNATIONAL TRENDS

The international trend of an ageing population and rising incidents of chronic disease has placed increasing pressure and demand on health care services, (Lizarondo, Kumar, Hyde & Skidmore 2010). In addition, changes in patient expectations from passive patient to active consumer has added to workplace pressures and facilitated the need for increasing numbers of health professionals and paraprofessionals to provide appropriate and timely care to all patients. Increasing service demand and the rising costs of delivering health care has seen the rise of delegated roles, such as the allied health assistant. For example, the introduction of the Assistant Practitioner (AP) role in the UK was a policy initiative to complement the work of registered professionals in both hospital and community settings (NSW Health, 2013). While the allied health assistant role has facilitated a more patient-centred service, evidence suggests it has also led to the boundaries between groups of health care professionals shifting and blurring, with 'role substitution' and 'role enhancement' becoming relatively commonplace, especially amongst allied health professionals (Thurgate et al, 2013; Daker-White et al, 1999).

1.1.2 AUSTRALIAN TRENDS

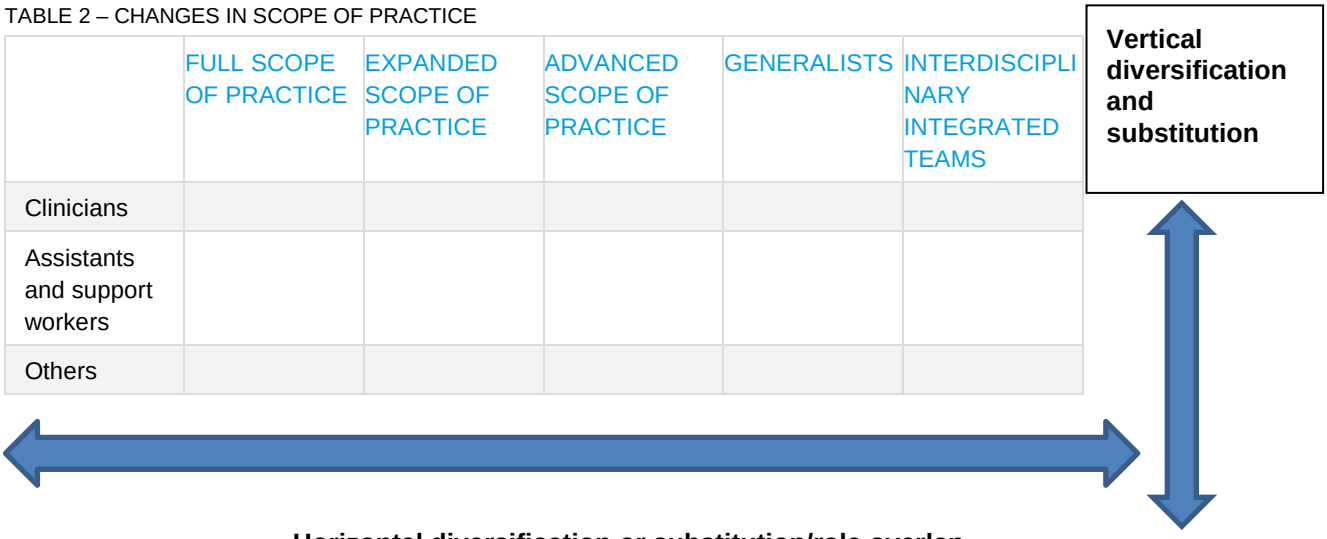
Similar to trends internationally, Australia is also experiencing an ageing population, higher incidents of chronic disease and increasing user demand. Recent statistics published by the Commonwealth Department of Health indicate that perhaps 50 per cent of Australians have a chronic disease (2015). Against this background of chronic disease burden is the paradigm posed by the high rates of malnutrition found in hospitalised patients in Australia and internationally, which continues to often be unrecognised and, therefore, untreated (see for example Watson et al., 2009; Agarwal et al., 2012).

This increase in long-term chronic diseases and more complex conditions has been accompanied by workforce shortages, particularly in aged care, where it is estimated that 60 per cent of the workforce will retire in the next ten years (Health Workforce Australia, 2014). Workforce shortages have also been exacerbated by increasing specialisation among the health workforce which has resulted in a mismatch between the needs of consumers and the location and equitable distribution of the workforce (Health Workforce Australia, 2014).

These skill shortages, changing demand and costs pressures have driven new thinking around the best way to deliver health care to ensure the health workforce meets current and future demand (Health Workforce Australia, 2014). As is the case internationally, Australia is increasingly viewing the allied health assistant (AHA) role as an important contributor to improved flexibility in the health workforce (Health Workforce Australia, 2014). Health Workforce Australia (2014) outlined how the scope of practice of the Australian health workforce could change in the future, with changes in the scope of practice for the assistant workforce a crucial part of this reform (see table overleaf). Key to their suggested reform agenda is the exchange or overlap of roles. Where reform to one sector of the workforce is undertaken, such as reserving clinicians for complex tasks, Health Workforce Australia suggests redesigning assistant roles so they perform the less complex work formerly done by the specialists.

TABLE 2 – CHANGES IN SCOPE OF PRACTICE

	FULL SCOPE OF PRACTICE	EXPANDED SCOPE OF PRACTICE	ADVANCED SCOPE OF PRACTICE	GENERALISTS	INTERDISCIPLINARY INTEGRATED TEAMS
Clinicians					
Assistants and support workers					
Others					



Conversely, while there is recognition that the AHA workforce may play a valuable role in contributing to the breadth and depth of services, their roles are often not clearly defined (Health Workforce Australia, 2014). This difficulty defining the scope of the AHA workforce generally is reflected in the dietetic support worker role, which has undergone a number of changes in recent years. The following sections explores the roles and functions of dietetic support workers in health services and delivery of food services in Australia and internationally (UK and US).

1.2 DIETETIC SUPPORT WORKERS

1.2.1 COMPARISON OF ROLES

Table 2 overleaf provides a comparison of the role of the dietetic support worker role across Australia, the UK and the US, looking specifically at the education level required, pay scale, career path and area and responsibility of work. A discussion of variation and overlap in roles has been included following the table. Particular consideration has been given to the following

- registration and education requirements
- level of supervision and responsibility.

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TABLE 3 – INTERNATIONAL COMPARISON OF DIETETIC SUPPORT WORKER ROLES

AUSTRALIA				
Definition	Regulations	Education/Pay scale	Career path	Scope
Dietetic support workers are health care workers with the knowledge and skills to support professionally qualified dietitians in delivering nutritional care programs to clients.	None	Certificate III in Nutrition and Dietetic Assistance and IV in Allied Health Assistance (note these are being reviewed/updated) Median weekly earnings: $1201 to $1500.	Currently not possible to use credits from a Certificate IV towards an undergraduate allied health course.	Work in both clinical and community settings and assist with the dietetic program as directed by the supervising clinical dietician. Typical tasks include: ▪ risk screening and identifying and reporting factors that place patients at nutritional and hydration risk ▪ applying clinical nutrition/therapeutic diet protocols as delegated ▪ assisting with implementation and monitoring of prescribed nutrition care plans ▪ facilitating and monitoring orders to patient food services ▪ managing and coordinating the provision of enteral feeds, commercial oral supplements and infant feeding formulas ▪ communicating to other health service personnel regarding patient therapeutic diet requirements ▪ supporting the provision of basic nutrition advice/education
UNITED KINGDOM				
Definition	Regulation	Education/Salary	Career path	Scope
According to the British Dietetic Association (BDA), there are no universally accepted definitions of the Dietetic Support Worker (DSW) or AP role. However, DSWs most commonly support dietitians in delivering nutritional advice and care to patients. APs deliver dietetic care at a higher level of knowledge and skill than DSWs and perform aspects of dietetic care and clinical work previously only delivered by dietitians.	There are no formal statutory regulations for DSWs, however, they are still expected to abide by certain standards or practice, including a duty of care to the patient/client under civil law and professional codes of practice (eg BDA Code	There is no recognised or mandatory qualification required to become a DSW. Unlike DSWs, APs require formal training, however, accredited work-based training and qualifications for APs varies. Annual salary ranges between AU$37,306 and	There is no clearly defined career structure or pathway for DSWs and APs.	DSWs undertake a range of clerical and administrative tasks, in addition to clinical duties and health promotion activities. The types of clinical duties DSWs may perform include: ▪ monitoring patients with long-term conditions, providing basic dietary advice ▪ checking food record charts, and patients' biochemistry ▪ undertaking a range of health promotion and health awareness activities

	of Professional Conduct)	$80,644 depending on experience/training.		Experienced APs are able to undertake nutritional assessments, with the supervision and guidance of a dietitian. Apart from this distinction, the types of tasks undertaken by APs are generally the same as the tasks performed by DSWs.
USA				
Definition	Regulation	Education/Salary	Career path	Scope
According to the Academy of Nutrition and Dietetics, registered dietetic technicians are educated and trained at the technical level to deliver nutrition services. They work under the supervision of registered dietitian nutritionists in hospital settings, but may work independently in other settings, such as schools, day-care centres, correctional facilities, health clubs, and community health programs. The Commission of Dietetic Registration (CDR) defines the DTR as: an individual who has met current minimum requirements by successfully completing an Associate degree or a Baccalaureate degree and the Registration Examination for Dietetic Technicians.	DTRs in the US have to complete nationally recognised qualifications for registration with the CDR Note – difference between registration and regulation. Only dietitians appear to have to work under state licensure provisions.	Accreditation as a Dietitian Technician (registered) (DTR) requires the completion of a two-year program from an American Dietetic Association (ADA) accredited community college (n.b. this is equivalent the an Australian TAFE or private college) and successful completion of a national exam given by the Commission on Accreditation for Dietetics Education (CADE) and accrue 50 hours of approved continuing professional education every five years (however non-registered Dietitian Technicians can still be employed as a Dietitian Technician). Average pay nationally is AU$22.65 per hour. Pay generally varies between AU$17.33 per hour and AU$31.92.	An issue with the career path for DTRs has arisen in recent years with the number of educational programs for DTRs declining.	DTRs provide clinical assistance to dietitians and have a degree of autonomy and responsibility higher than their counterparts in other countries (e.g. reviewing medication, formulating medical intervention plans and reviewing medical charts). Other duties undertaken by DTRs include ▪ observing patient food intake and reporting progress and dietary problems to dieticians ▪ planning menus and diets, guiding patients and families in food selection ▪ preparation and menu planning based on nutritional needs and established guidelines ▪ obtaining and evaluating dietary histories of individuals to plan nutritional programs ▪ nutrition screening ▪ providing basic information on diabetes ▪ collaborating with other health care providers ▪ research, coordination, and teaching of food service management

Sources: Academy of Nutrition and Dietetics 2013a; Academy of Nutrition and Dietetics 2013b; DAA 2007; BDA 2013; Healthcare salaries website 2015; NSW Health 2013; Payscale website

REGISTRATION AND EDUCATION REQUIREMENTS

As outlined in the table above, only the US has registration requirements for dietetic support workers.[1] In order to become registered, DTRs are required to meet certain education requirements, for example, successful completion of a two-year program from an ADA accredited community college (Academy of Nutrition and Dietetics, 2013a). DTRs also have to undertake ongoing continuous education every five years to maintain their DTR status (Academy of Nutrition and Dietetics 2013a).

Conversely, in the UK, DSWs do not have to undertake any mandatory training to be employed and as a result there are a number of practising DSWs without formal qualifications. According to the literature there is some resistance to mandatory qualification for DSWs, with 38 per cent of DSW in a recent study disagreeing that there should be a recognised qualification for DSWs (Le Cornu et al 2010). One of the reasons given for opposition to a nationally recognised qualification for DSWs was the variation in the DSW role, and concern that a standardised qualification might not take in to account variation in the responsibilities and duties of DSWs (Le Cornu et al, 2010). While there are no mandatory education requirements, the BDA recommends that DSWs complete Scottish/National Vocational Qualification Level 3 or its equivalent under the National Health Service (NHS) nine level career framework (BDA 2013). APs in the UK are expected to have completed qualifications at the equivalent of a Foundation Degree level and typically work at a National Health System Band 4 level –between Band 5 for registered nurses, and Band 3 for DSWs (Thurgate 2013).

The UK experience is similar to Australia, which also has no mandatory education requirements for the dietitian and nutrition assistant role, though most dietetic support workers have usually completed Certificate III in Nutrition and Dietetic Assistance and many have completed Certificate IV in Allied Health Assistance (DAA 2007).

LEVEL OF SUPERVISION AND RESPONSIBILITY

The level of supervision and responsibility of dietetic support workers varied across the three countries surveyed. In Australia, dietetic support workers at a Certificate III level tend to work under direct supervision and to not deliver programs or therapeutic intervention, whereas support workers at the Certificate IV level are able to deliver therapeutic and program related activities under the guidance of a dietitian (ACT Health, 2007). There are no guidelines governing the supervision of support workers; however, the Dietitians Association of Australia (DAA) has developed a scope of practice for nutrition and dietetic assistants, which includes advice on supervision. The DAA recommends that dietitian and nutrition assistants are supervised by appropriately qualified dietitians. In the absence of clinical dietitians, the DAA supports a shared supervision model, where supervision is provided by a senior nursing position, or other allied health professionals or manager (DAA, 2007).

In the UK, the DSW role is developing and extending, with some DSWs undertaking tasks not dissimilar to dietitians; however the difference is in the level of responsibility and autonomy expected of DSWs (BDA 2013). DSWs work under the direction and supervision of a dietitian, and perform tasks delegated by dietitians in accordance with particular organisational protocols (BDA, 2013). Although some individual tasks undertaken by DSWs might be the same as those undertaken by dietitians, DSWs have less autonomy and more structured boundaries regarding what they can and cannot do, with established protocols for when they are required to refer to or handover to a dietitian (BDA, 2013). In a study on the current and future role of DSWs, the majority (two-thirds) of DSWs and dietitians surveyed were reportedly satisfied with the level of supervision and responsibility given to DSWs (Le Cornu, et al 2010).

While APs are expected to work more independently than DSWs, with some APs performing their own nutritional assessments, they are still expected to act in a supportive or assistive capacity to dietitians (BDA, 2013; Thurgate, 2013). The literature suggests that, given the relatively recent introduction of the AP role, APs require a mentor who understands the ‘new role’ and levels of competency required (Thurgate et al, 2013: 248).

In the US, DTRs have a degree of autonomy and responsibility higher than their counterparts in other countries and may be responsible for reviewing medication, formulating medical intervention plans and reviewing medical charts. The scope of the DTR role has also reportedly expanded in recent years to

[1] This is consistent with registration of dietitians across jurisdictions, with formal registration of clinical dietitians only a requirement for practice in the USA.

include research, coordination, and teaching of food service management. The expansion of the role has purportedly raised some issues around the level of supervision that DTRs require. While dietitians are required to supervise DTRs, there is some ambiguity as to the level of supervision required, which may vary depending on the context in which the service is provided (ADA 2008).

BARRIERS AND ENABLERS TO THE DIETETIC SUPPORT WORKER ROLES

The literature identified a number of barriers and enablers to the dietetic support worker role across each of the three countries surveyed, these barriers include:

- **Absence of regulations governing the workforce** - This has reportedly contributed to perceptions that dietetic support workers could have a negative impact on quality and safety standards in the workplace (Health Workforce Australia, 2014).

- **Protectionism from some dietitians** – There is evidence that some dietitians feel threatened by the increasing amount of responsibility given to dietetic support workers (Le Cornu et al., 2010).

- **Vague and non-specific role definition** – There is evidence to suggest that vague and non-specific role delineation can not only erode respect for dietetic support workers, it can also result in lower morale among the workforce which can then have a potentially negative impact on patient outcomes (Stute et al 2014; Le Cornu et al 2010; Lizarondo et al 2010).) Thurgate et al argue that in order for the AP role to be 'fit for purpose', it is important to have a job description which outlines core competencies and the boundaries and educational requirements of the role (2013, p.248).

- **The degree of responsibility** - The primarily assistive role that DSWs play is sometimes a source of frustration, with some DSWs reporting that they are solely responsible for 'menial tasks' and the 'jobs dietitians don't want to do' (Le Cornu et al., 2010, p.233).

- **Absence of clear career path/low levels of pay** – Evidence suggests frustration among some dietetic support workers about the absence of a structured career pathway and low levels of pay (Le Cornu et al, 2010). In the US DTRs with 20 years or more of experience receive the same incomes as those with ten years' experience (Pay Scale website, 2015)

- **The lack of formal recognition or acknowledgement of the importance of the dietetic support worker role**, which has resulted in a number of consequences for staff, including low staff morale among some dietetic support workers. In the US some DTRs are reportedly experiencing stress and burn out as a result of budget and staff cutbacks. In addition, some DTRs are working in positions which they feel overqualified for, resulting in staff feeling unfulfilled and unappreciated (Fall et al., 2003).

Many of the enablers for dietetic support worker roles are the antithesis of the barriers, notably, having:

- a clearly defined job description

- adequate training and supervision

- appropriate levels of pay and a clear career pathway.

There is evidence which suggests that although some dietetic support workers may not feel the need for training, training programs can have a positive impact by providing the opportunity for collaborative learning (Munn et al., 2013). In Australia, support workers who received the opportunity to undertake training after many years of working in the job reported a number of benefits, namely, the opportunity to learn theory which complemented the practical skills they had learnt through on the job training. The certification also reportedly contributed to their sense of self-esteem and their level of commitment to the role (Health Workforce Australia, 2014).

1.3 WORKFORCE MODELS

The literature did not identify a particular 'model' for a dietetic support worker role; however, there were examples of models for the broader AHA role and support worker role. Health Workforce Australia (2014) developed a typology of 12 models of assistant care and their contribution to the health workforce. Some

of these are not relevant to the dietetic support worker role, as they specifically relate to nursing, however, some of the models outlined in the table below incorporate relevant features.

TABLE 4 – MODELS OF ASSISTANT CARE

MODEL	EXAMPLE
Single-discipline Allied Health Assistant	Relieve professionals, cost-effective teamwork, enlarge or enhance the service in the home
Advanced Assistant	Delegated, assigned workload, coordination and linkages facilitation, assistance
Assistant Traineeship Discipline Specific	Cost efficiencies by developing the assistant through a traineeship approach
Dietetic Assistant in rural and remote region	Expanded role due to workforce shortages - therapy aide roles were expanded to become allied health assistants – this freed up the dietitian's time to see more patients and the wait time for a dietetic appointment dropped from two months to under two weeks
Clinical Support Officer	Relieve allied health professional of their clerical work and administrative duties
Community Care Worker	Continuity of care, alert system for early intervention, covering gaps-service enlargement, supplementing or freeing up professionals

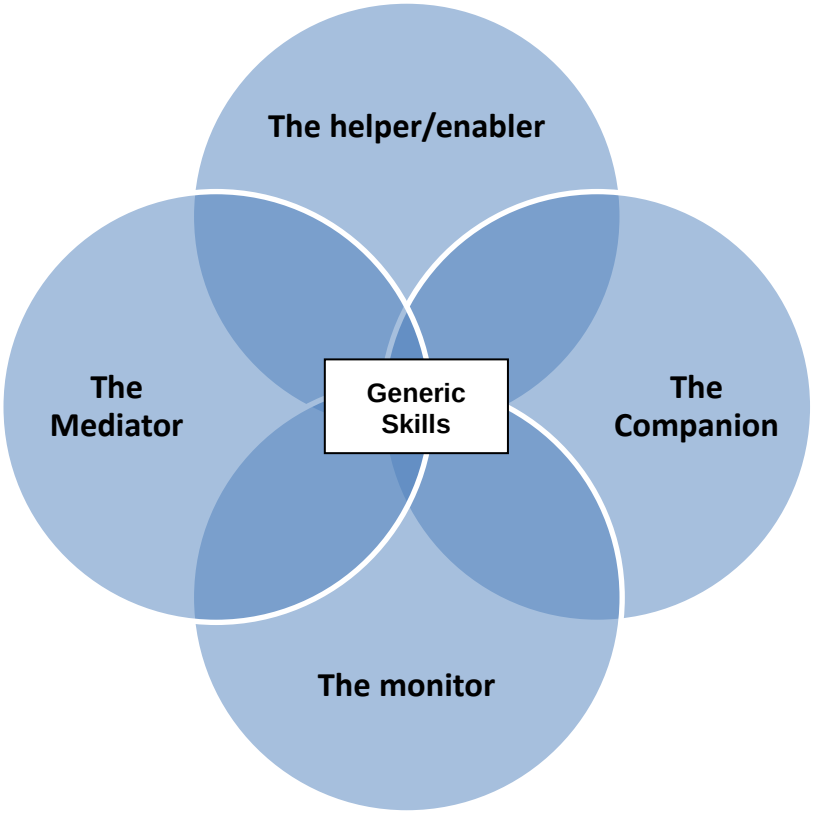
Research undertaken in the UK on the roles of support workers in health and social care, found that despite the heterogeneity of support worker roles, they shared some common features or attributes, these commonalities were grouped into four key domains of work and four core roles (or attributes) of support workers (Moran et al., 2011). The four domains of support worker are outlined in the table below.

TABLE 5 – FOUR DOMAINS OF THE SUPPORT WORKER ROLE

DOMAINS OF WORK	EXAMPLES
Direct care	Working directly with patients, usually in roles that have a therapeutic focus, providing personal care, medical assistance and emotional and social support.
Indirect care	Assisting with treatment planning/reviewing care programs and monitoring progress.
Administration	General administration duties, admission and discharge process, checking and maintaining equipment
Facilitation	Encourage cross-agency working, continuity of care, support professionals, promote interdisciplinary communication, feedback to professionals and informal assessment of patient change

The four attributes of support workers identified in the literature are outlined in figure 4 overleaf (Moran et al 2011).

FIGURE 1 – ROLES AND ATTRIBUTES OF THE SUPPORT WORKER ROLE



According to Moran et al. (2010), the helper /enabler aspect of the support worker role encompasses the incidental support that support workers provide patients and practitioners, such as providing personal care, which ultimately influences a patient's sense of wellbeing. The companion aspect of the support worker role is the emotional support they provide patients by talking and listening to them. The facilitator component of the support worker role refers to the fact that support workers can act as a conduit to the patient-qualified professional relationship. The monitor aspect of the support worker role is facilitated by the direct care and contact with patients that most support workers have which enables them to observe and monitor changes in patient health (Moran et al., 2010).

The table below draws together some of the aspects of the models or frameworks discussed above to map where the dietetic support worker roles identified in the literature might fit in terms of level of complexity and responsibility – the level at which each dietetic support worker operates is related to their education level.

TABLE 6 – COMPARISON OF DIETETIC SUPPORT WORKER ROLES

LEVEL	EXAMPLES	RESPONSIBILITIES/TASKS
Highest level of complexity/autonomy	DTR (USA) completion of a two-year program from an ADA accredited community college.	Reviews medication, formulates medical intervention plans and reviews medical charts Research, coordination, and teaching of food service management
Increased complexity/autonomy	AP (UK) and dietetic support worker with a Certificate IV in Allied Health Assistance (Australia)	Collect data to assist with nutritional assessments (under supervision). Undertake some tasks independently.
Lowest level of complexity/autonomy	DSW (UK) and dietitian assistant either with no qualifications or Certificate III in Nutrition and Dietetic Assistance (Australia)	Always need to work under the supervision of dietitian or other professional.

1.3.1 RELATIONSHIP OF DIETETIC SUPPORT WORKERS TO CLINICAL DIETITIANS AND FOOD SERVICES

There was limited evidence in the literature of the relationship of dietetic support workers with food services specifically. It was however, clear that the extent to which dietetic support workers are directly involved with food services varies depending on the context in which they are employed. Dietetic support workers in Australia assist in implementing and monitoring nutrition care plans and in facilitating and monitoring patient orders with food services (NSW Agency for Clinical Innovation, 2014). In the UK, DSWs and APs check food record charts and some APs undertake nutritional assessments under the supervision and guidance of a dietitian. In the US, DTRs plan menus and diets based on patients' nutritional needs and some DTRs are even involved in teaching food service management (Academy of Nutrition and Dietetics 2013a; Academy of Nutrition and Dietetics, 2013b).

Although the literature on the relationship between dietetic support workers and food services was limited, a number of sources referred to the role that dietetic support workers play in supporting dietitians more broadly. Some of the literature suggests that the introduction of AHA is a cost-effective addition to the allied health workforce (Clinical Education & Training Institute, 2011). In Australia, there is evidence to suggest that employing dietetic support workers (and other allied health assistants) has enabled the delivery of more comprehensive care and increased patient satisfaction with services (NSW Health, 2013). There is also evidence that dietetic support workers have improved patient outcomes, with studies suggesting that dietetic support workers have helped (a) improve patient diets, (b) increase the provision of interventions among patients at risk or malnutrition, and (c) reduce mortality rates (Duncan et al., 2005 and Aliakbari et al., 2005, cited in ACT Health, 2007, p.18-19; Maunder et.al, 2015). At the same time, the literature suggest that it is not dietetic support workers themselves as a group that has the biggest impact on patient outcomes, but rather the contribution that the dietetic support workers have on the whole team in terms of increased productivity and capacity which contributes to improved outcomes (Health Workforce Australia, 2014).

In the UK, a survey on the DSW role found the vast majority (over 90%) of dietitians reported the DSW position had helped to improve their working lives (Le Cornu et al., 2010). Dietitians reported that DSWs enabled them to undertake more complex work and to broaden the scope of support they provided to patients. DSWs were also seen as strengthening the skill base of the team and providing alternative points of view (Le Cornu et al., 2010). The literature also suggests that by assisting and complementing the roles undertaken by dietitians, APs have enabled dietitians to broaden their scope of practice which has ultimately led to improvements in services for patients (BDA, 2013). Research on manager's experience training APs reported that APs have a positive impact on both the quality and standard of care provided to patients (Thurgate, 2013, Moran et al 2010).

In the US, DTRs have reportedly had a positive impact on outcomes as part of a Nutrition Care Process (NCP) (Barritta de Defranchi et al., 2009). According to the Academy of Nutrition and Dietetics, registered dietitians and DTRs work together to provide nutrition care to patients. While the registered dietitians supervises the activities of DTRs, the DTR plays an important role in acting as a conduit of information to registered dietitians and nurses, particularly because they are often the first staff member from the team to talk to a patient. By facilitating communication between staff and patients DTRs contribute to the overall continuum of care (Academy of Nutrition and Dietetics 2013a; Academy of Nutrition and Dietetics 2013b).

1.4 CONCLUSION

While there are differences in the role played by dietetic support workers in each of the three countries profiled, there appears to be a number of commonalities, both in terms of the perceived benefits and issues and challenges. Commonly reported benefits of the support worker role were the support they provide dietitians in delivering a continuum of care to patients and in facilitating communication channels between patients, dietitians and other health staff. The support worker role also reportedly frees up the dietitians time to deliver more complex and specialised support. Yet, despite the reported benefits of the role, support workers do not always report feeling appreciated or valued. Some of the common issues across the three countries include:

- **the absence of clear boundaries between dietitians and support workers -** this has contributed to negative perceptions of the support worker role among dietitians and resulted in some dietitians

feeling threatened. Lack of clear demarcation between the roles has also reportedly prevented the development of collaborative working relationships between dietitians and support workers.

- **the lack of a clearly defined role, appropriate levels of pay, and a structured career pathway** has resulted in support workers feeling that they are undervalued and contributed to low staff morale among some of the workforce.

Evidence suggests that these issues could be alleviated by ensuring that the scope of practice of the dietetic support worker role is clearly defined. At minimum, this includes: a detailed position description which outlines the skills and competencies (education level) required and supervision and delegation guidelines. There appears to be some value in having a traineeship /apprenticeship style approach to training dietetic support workers, though more exploration of this approach is required before any definitive conclusions can be made.

The literature suggests there is no one 'model' of service delivery and the exact requirements of the dietetic support worker role will vary depending on the context in which they are working. Domains of work commonly undertaken by dietetic support workers include providing direct and indirect care to patients, administration tasks and helping to facilitate cross-agency working. The level of complexity and responsibility dietetic support workers operate at is generally related to the education requirements of their position, with DTRs in the US having the highest educational requirements and the highest level of responsibility of the three countries profiled. There was little evidence in the literature on the dietetic support workers to food services specifically, though what evidence there was suggests that there needs to be open lines of communication between dietetic support workers, dietitians, and hospital staff to ensure that dietetic support workers are able to maximise the flexibility of the role and contribute to the food planning, preparation, and delivery most effectively .

1.5 REFERENCE LIST

ACT Health 2007 *Literature Review: Feasibility of supporting the introduction of the Certificate IV in Allied Health Assistance: Podiatry and the Certificate IV in Allied Health Assistance: Nutrition in the Australian Capital Territory* ACT Health Allied Health Adviser's Office: Canberra

Academy of Nutrition and Dietetics 2015 *What is an RDN and DTR?* Accessed 21 August 2015 available at http://www.eatrightpro.org/resources/about-us/what-is-an-rdn-and-dtr

Academy of Nutrition and Dietetics 2013a Scope of Practice for the Registered Dietitian *Journal of the Academy of Nutrition and Dietetics* 113 (6) S17-S28

Academy of Nutrition and Dietetics 2013b Revised 2012 Standards of Practice in Nutrition Care and Standards of Professional Performance for Registered Dietitians *Journal of the Academy of Nutrition and Dietetics* 113 (6) S29-S45

Agarwal E, Ferguson M, Banks M, Bauer J, Capra S and Isenring E 2012 Nutritional status and dietary intake of acute care patients: Results from the Nutrition Care Day Survey 2010. Clinical Nutrition 31(1): 41-7

American Dietetic Association (now called the Academy of Nutrition and Dietetics) 2008 , *Final Report of the Phase 2 Future Practice and Education Task Force*, Accessed 21 August 2015 availabe at http://www.eatrightpro.org/~/media/eatrightpro%20files/practice/future%20practice/phase_2_future_practice_education_task_force_final_report.ashx

Barritta de Defranchi, R L, Nelson, J, K 2009 *Evolution and trends of the dietetics profession in the United States of America and in Argentina: North and South united by similar challenges*

British Dietetic Association (BDA) 2013 *Dietetic Support Worker & Assistant Practitioner Roles* The British Dietetic Association

Clinical Education & Training Institute 2010 *Evaluation – Rural Allied Health Assistant (RAHA) Interim Report 2* Accessed 21 August 2015 available at:http://www.ruralheti.health.nsw.gov.au/__documents/initiatives/rural-allied-health-project/raha_1226_interim_report_2_21.11.11.pdf

Le Cornu K. A, Halliday, D. A. Swift, L, Ferris, L. A and Gatiss, G, A 2010 The current and future role of the dietetic support worker *Journal of Human Nutrition* 23, 230–237

Dietitians Association of Australia (DAA) 2007 Scope of practice – support staff in nutrition & dietetic services Accessed 21 August 2015 available at http://dmsweb.daa.asn.au/files/DINER/SOP%20_Nutrition%20Assistants_11Sept07.pdf

Daker-White, G., Carr A.J., Harvey, I., et al 1999 A randomised controlled trial: Shifting boundaries of doctors and physiotherapists in orthopaedic outpatient departments *Journal of Epidemiological Community Health*, 53, 643–650.

Dall'Oglio, I, Nicola, R, Di Ciommo, V, Bianchi, N et al, 2014A Systematic review of Hospital Foodservice Patient Satisfaction Studies Journal of the Academy of Nutrition and Dietetics 115 (4) 567-584

Fall, M, L, Wolf, N, Schiller, M, Wilson, S, L 2003 Dietetic technicians report low to moderate levels of burnout Journal of the American Dietetic Association, 103 (11) 1520-1522

Healthcare salaries.com 2015 *Dietetic technician salary* Accessed 24 August 2015 available at http://www.healthcare-salaries.com/technicians/dietetic-technician-salary

Health Workforce Australia 2014 *Health Workforce Australia 2014: Assistants and support workers: workforce flexibility to boost productivity – Full report* Accessed 21 August 2015 available at http://www.hwa.gov.au/sites/default/files/HWA%20Assistants%20and%20Support%20Workers_Full%20report.pdf

Hooker, R, S, Williams, J, H, Papneja, Sen, Hogan, P 2012 Dietetics Supply and Demand: 2010-2020 *Journal of the Academy of Nutrition and Dietetics*; 112 S75-S91

Kersten, P., McPherson, K., Lattimer, V., George, S., Breton, A., & Ellis, B 2007 Physiotherapy extended scope of practice: Who is doing what and why? *Physiotherapy*, 93(4), 235–242

Lizarondo, L; Kumar, S., Hyde, L., & Skidmore, D 2010 Allied Health Assistants and what they do: A systematic review of the literature *Journal of Multidisciplinary Healthcare*, 3,143-153

Maunder, K., Lazarus, C., Walton, K., Williams, P., Ferguson, M. & Beck, E. 2015 Energy and protein intake increases with an electronic bedside spoken meal ordering system compared to a paper menu in hospital patients. *Clinical Nutrition ESPEN,* 10 (4), e134-e139

NSW Agency for Clinical Innovation 2014 Choices: the patient meal selection process. Accessed 6 November 2015 available at http://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0018/227520/ChOICES-Patient-Menu-Selection-Process-Presentation-June2014.pdf

NSW Health 2011 *Nutrition Care Policy* Accessed 26 August 2015 available at http://www0.health.nsw.gov.au/policies/pd/2011/pdf/PD2011_078.pdf

NSW Health 2013 *Allied Health Assistant Framework* Accessed 21 August 2015 available at http://www0.health.nsw.gov.au/policies/gl/2013/GL2013_005.html

NSW Health 2012 *Allied Health Assistants Survey Results 2012* Accessed 21 August available at http://www.health.nsw.gov.au/workforce/alliedhealth/Documents/NSW-Health-2012-AHA-Survey-Results.pdf

Payscale. com 2015 *Diet Technician Registered* Accessed 21 August 2015 Available at http://www.payscale.com/research/US/Job=Diet_Technician_Registered_(DTR)/Hourly_Rate

Stute, M, Hurwood, A, Hulcombe, J and Kuipers, P 2014 Pilot implementation of allied health assistant roles within publicly funded health services in Queensland, Australia: results of a workplace audit *BMC Health Services Research* 14

Sheehan-Smith, L 2006 Key facilitators and nest practices of hotel-style room service in hospitals *Journal of the American Dietetic Association* 104 (4), 581-586

Thurgate, C, Macgregor, J, O'Keefe, H 2013 Managers experience of training the associate practitioner role *Journal of Nursing Management* 21, 242–250

Walton, K; Williams, P and Tapsell, L 2006 What do stakeholders consider the key issues affecting the quality of foodservice provision for long-stay patients? *Journal of Foodservice* 17, 212–225

Waterson C, Fraser A, Banks M, Isenring E, Miller M, Silvester C, et al. 2009 Evidence based practice guidelines for the nutritional management of malnutrition in adult patients across the continuum of care. Nutrition and Dietetics 66 (3), S1-S34.

Appendix B Research instruments

Workforce Planning & Development Branch, NSW Ministry of Health

Nutrition and Dietetic Assistant Workforce Mapping

Discussion Guide for Nutrition and Dietetic Assistants – 22 July 2015

Explanatory notes

- This issues guide should not limit but provide a guide of the range and coverage of issues that will come out of the research project.
- It is a guide for discussion, and will not be used as a script—phrasing, wording, and order will be adapted as appropriate.
- This guide does not represent a complete list of the questions that will be asked or covered in each focus group. The coverage and flow of issues will be guided by the researchers and informed by the participants. All questions are fully open-ended.
- Some questions are similar because they are trying to get at an issue from a number of angles and to validate responses/ views.
- Reported issues/ data will be probed for evidence/ examples wherever relevant.

Introduction (10 minutes)

- Introduction of self and project:
  - This research is being conducted by Urbis on behalf of the Workforce Planning & Development Branch of the NSW Ministry of Health.
  - Urbis is an independent interdisciplinary consulting firm offering services in planning, design, property, social planning, economics and research.
- Background and purpose:
  - The NSW Ministry of Health engaged Urbis to undertake research to improve understanding of a key component of the allied health assistant workforce in NSW: the Nutrition and Dietetic Assistant workforce.
  - Lessons learned through this research will inform the development of a model 'role description' for nutrition and dietetic assistants, and help guide the appropriate use of these roles in the provision of nutrition and dietetic services
- Confidentiality and anonymity.
- Length of focus group – no longer than 1.5 hours
- Each focus group participant is asked to provide their name and current position title.

Training and skills (10 minutes)

1. What do you think is the most important training for your current role? Anything else?

   [Probe for informal, on-the-job training, in-service training, formal qualifications, regular feedback from a Clinical Dietitian]

   - Why do you think this type of training is important?
   - In what ways has this type training personally helped you to prepare for or perform in your current role?

2. What skills and experience do you think are required to perform your current role? Anything else?

   [Probe for clinical and non-clinical skills and experience]

   - Why do you think these skills and experience are required?

Current work duties (25 minutes)

3. How many shifts do you typically work across a seven-day week?

   [Probe for consistency of shift arrangements]

4. What drives the number of shifts you typically work across a seven-day week?

   [Probe for personal issues (e.g. choice, health, family) and work pressures (e.g. rostering limits, staffing]

5. Can you describe what you do during a typical sift? Anything else?

   [Probe for variation across participants]

6. Could you briefly describe any clinical tasks that you perform during a typical shift?

   [If prompted, provide the following definition of clinical tasks: CLINICAL TASKS are tasks directly related to patient care and treatment. Examples may include malnutrition screening, application of clinical nutrition/therapeutic diet protocols etc.]

7. Do you think your clinical training and skills are currently being adequately utilised? Why? Why not?

   - What could be done to ensure that your clinical training and skills are fully utilised? Anything else?

8. Could you describe any occasions in which you have been asked to perform clinical tasks that you believe are beyond the scope of your role?

   - What could be done to ensure that you generally feel comfortable performing all of the clinical tasks that you are asked to perform? Anything else?

9. Based on your understanding, what is the process for Nutrition Risk Assessment at the hospital or hospitals where you work?

10. Could you briefly describe any non-clinical and administrative tasks that you perform as part of a typical shift?

    [Probe for following tasks: Plate meals, Deliver meal trays to patients, Collect meal trays from patients, Wash dishes (e.g. pack dishwasher), Check trayline]

11. What role do you currently play in taking patient food orders, plating food, and delivering meals?

Communication and supervision (15 minutes)

12. Which Allied and Medical Health Professionals do you communicate with during a typical shift?

    - What are your main reasons for communicating with these Allied and Medical Health professionals?
    - And how do you communicate with these Allied Health and Medical Professionals?

    [Probe for effectiveness of communication channels]

13. And which Patient Food Services' staff do you communicate with during a typical shift?

    - What are your main reasons for communicating with these staff members?
    - And how do you communicate with these staff members?

    [Probe for effectiveness of communication channels]

14. What are your current supervisory arrangements?

    [Probe for informal/ formal clinical supervision (e.g. providing feedback about a patient's nutrition care plan) and non-clinical supervision (e.g. rostering, task allocation]

    - What do you think could be done to improve your current supervisory arrangements? Anything else?

Enhanced Service Delivery Model (25 minutes)

[Distribute overview of revised model]

15. What do you think are the key strengths of the enhanced service delivery model? And what about the weaknesses?

16. How well do you think the enhanced service delivery model will function in the hospital in which you work? Why do you say that?

    - How could the enhanced service delivery model be modified to function successfully in the hospital in which you work?

17. What impact do you think the implementation of this enhanced service delivery model will have on your role? Anything else?

    [Probe for positive and negative impacts]

18. Under this model, dietetic staff will not be responsible for taking patient meal orders. What do you think are the key advantages and disadvantages of this approach? Anything else?

19. If you were not required to take patient meal orders, how do you think that this would impact upon patient care and clinical outcomes? Anything else?

    [Probe for positive and negative impacts]

Workforce Planning & Development Branch, NSW Ministry of Health

Nutrition and Dietetic Assistant Workforce Mapping

Discussion Guide for Food Services Staff – 23 July 2015

Explanatory notes

- This issues guide should not limit but provide a guide of issues that will come out of the research project.
- It is a guide for discussion, and will not be used as a script—phrasing, wording, and order will be adapted as appropriate.
- This guide does not represent a complete list of the questions that will be asked or covered in each focus group. The coverage and flow of issues will be guided by the researchers and informed by the participants. All questions are fully open-ended.
- Some questions are similar because they are trying to get at an issue from a number of angles and to validate responses/ views.
- Reported issues/ data will be probed for evidence/ examples wherever relevant.

Introduction (10 minutes)

- Introduction of self and project:
  - This research is being conducted by Urbis on behalf of the Workforce Planning & Development Branch of the NSW Ministry of Health.
  - Urbis is an independent interdisciplinary consulting firm offering services in planning, design, property, social planning, economics and research.
- Background and purpose:
  - The NSW Ministry of Health engaged Urbis to undertake research to improve understanding of a key component of the allied health assistant workforce in NSW: the Nutrition and Dietetic Assistant workforce.
  - Lessons learned through this research will inform the development of a model 'role description' for nutrition and dietetic assistants, and help guide the appropriate use of these roles in the provision of nutrition and dietetic services
- Confidentiality and anonymity.
- Length of focus group – no longer than 1.5 hours
- Each focus group participant is asked to provide their name and current position title.

Training and skills (10 minutes)

1. What do you think is the most important training for your current role? Anything else?

   [Probe for informal, on-the-job training, in-service training, formal qualifications]

   - Why do you think this type of training is important?
   - In what ways has this type training personally helped you to prepare for or perform in your current role?

2. What skills and experience do you think are required to perform your current role? Anything else?

   - Why do you think these skills and experience are required?

Current work duties (25 minutes)

3. How many shifts do you typically work across a seven-day week?

   [Probe for consistency of shift arrangements]

4. What drives the number of shifts you typically work across a seven-day week?

   [Probe for personal issues (e.g. choice, health, family) and work pressures (e.g. rostering limits, staffing]

5. Can you describe what you do during a typical sift? Anything else?

   [Probe for variation across participants]

6. Could you briefly describe the specific tasks that you perform during a typical shift?

7. Do you think your training and skills are currently being adequately utilised? Why? Why not?

   - What could be done to ensure that your training and skills are fully utilised? Anything else?

8. Could you describe any occasions in which you have been asked to perform tasks that you believe are beyond the scope of your role?

   - What could be done to ensure that you generally feel comfortable performing all of the tasks that you are asked to perform? Anything else?

9. Based on your understanding, what is the process for Nutrition Risk Assessment at the hospital or hospitals where you work?

10. What role do you currently play in taking patient food orders, plating food, and delivering meals?

Communication and supervision (15 minutes)

11. Which Allied and Medical Health Professionals do you communicate with during a typical shift?

    - What are your main reasons for communicating with these Allied and Medical Health professionals?
    - And how do you communicate with these Allied Health and Medical Professionals?

    [Probe for effectiveness of communication channels]

12. And which Patient Food Services' staff do you communicate with during a typical shift?

    - What are your main reasons for communicating with these staff members?
    - And how do you communicate with these staff members?

    [Probe for effectiveness of communication channels]

13. What are your current supervisory arrangements?

    - What do you think could be done to improve your current supervisory arrangements? Anything else?

Enhanced Service Delivery Model (25 minutes)

[Distribute overview of revised model]

14. What do you think are the key strengths of the enhanced service delivery model? And what about the weaknesses?

15. How well do you think the enhanced service delivery model will function in the hospital in which you work? Why do you say that?

    - How could the enhanced service delivery model be modified to function successfully in the hospital in which you work?

16. What impact do you think the implementation of this enhanced service delivery model will have on your role? Anything else?

    [Probe for positive and negative impacts]

17. Under this model, dietetic staff will not be responsible for taking patient meal orders. What do you think are the key advantages and disadvantages of this approach? Anything else?

18. What sort of training, if any, do you think that you would need prior to the Enhanced Service Delivery Model being implemented in the hospital in which you work? Anything else?

    [Probe for training related to providing basic nutritional advice, assisting access to food, software training]

Workforce Planning & Development Branch, NSW Ministry of Health

Nutrition and Dietetic Assistant Workforce Mapping

Discussion Guide for Stakeholders – 4 August 2015

Explanatory notes

- This issues guide should not limit but provide a guide of the range and coverage of issues that will come out of the research project.
- It is a guide for discussion, and will not be used as a script—phrasing, wording, and order will be adapted as appropriate.
- This guide does not represent a complete list of the questions that will be asked or covered in each workshop. The coverage and flow of issues will be guided by the researchers and informed by the participants. All questions are fully open-ended.
- Some questions are similar because they are trying to get at an issue from a number of angles and to validate responses/ views.
- Reported issues/ data will be probed for evidence/ examples wherever relevant.

Introduction (10 minutes)

- Introduction of self and project:
  - This research is being conducted by Urbis on behalf of the Workforce Planning & Development Branch of the NSW Ministry of Health.
  - Urbis is an independent interdisciplinary consulting firm offering services in planning, design, property, social planning, economics and research.
- Background and purpose:
  - The NSW Ministry of Health engaged Urbis to undertake research to improve understanding of a key component of the allied health assistant workforce in NSW: the dietitian and nutrition assistant workforce.
  - Lessons learned through this research will inform the development of a model 'role description' for nutrition and dietetic assistants, and help guide the appropriate use of these roles in the provision of nutrition and dietetic services.
- Confidentiality and anonymity.
- Length of workshop – no longer than 2 hours (including break)
- Each workshop participant is asked to provide their name and current position title.

Role of Allied Health Assistants (15 minutes)

1. How have Allied Health Assistants been used in the hospitals in which you have worked? Anything else?

2. Are you aware of any other ways in which Allied Health Assistants have been utilised? Anything else?

3. *[Probe other States/ Territories and other countries]*

Nutrition and Dietetic Assistants (20 minutes)

4. Based on your experience, what are the key clinical tasks typically performed by Nutrition and Dietetics Assistants?

   [Probe for role in Nutrition Risk Assessment]

5. What other clinical tasks, if any, do you think could be performed by Nutrition and Dietetic Assistants?

   - What training, if any, would be required for Nutrition and Dietetic Assistants to be able to safely perform these clinical tasks?

6. What are some examples of the ways in which Nutrition and Dietetic Assistants have positively impacted upon patient care and clinical outcomes?

7. Based on your experience, what are the key non-clinical tasks typically performed by Nutrition and Dietetic Assistants?

   [Probe for role in taking patient food orders, plating food, and delivering meals]

8. In some hospitals Nutrition and Dietetic Assistants are responsible for taking patient meal orders. What do you think are the key advantages of this approach? And what about the disadvantages?

9. In some hospitals Patient Food Services staff are responsible for taking patient meal orders. What do you think are they key advantages of this approach? And what about the disadvantages?

10. What do you think are the key advantages of having Nutrition and Dietetic Assistants managed by Nutrition and Dietetics Departments? And what about the disadvantages?

    [Probe for opportunity of clinical supervision]

11. What do you think are the key advantages of having Nutrition and Dietetic Assistants managed by HealthShare? And what about the disadvantages?

Enhanced Service Delivery Model (30 minutes)

[Distribute overview of revised model]

Group Work Task One

- Groups of four to five participants

- Participants asked to work collaboratively with their group members to come up with a list of the ways in which the Enhanced Service Delivery Model could positively and negatively impact upon patient care and clinical outcomes.

- Group spokesperson reports lists back to the larger group, and answers are discussed.

12. How well do you think the Enhanced Service Delivery Model will function in hospitals across NSW? Why do you say that?

    [Probe for variation across metro/regional and hospital size]

13. Under this model, dietetic staff will not be responsible for taking patient meal orders. How do you think that this will impact upon patient care and clinical outcomes? Anything else?

    [Probe for positive and negative impact]

14. What training, if any , do you think Food Services Staff should complete prior to the Enhanced Service Delivery Model being implemented? Anything else?

    [Probe for training related to providing basic nutritional advice, assisting access to food, software training]

15. What impact do you think the Enhanced Service Delivery Model will have of the Nutrition and Dietetic Assistant workforce? Anything else?

    [Probe for positive and negative impact]

    - What could be done to minimise any negative impacts on this workforce? Anything else?

16. What about the dietetic workforce more broadly?

    [Probe for positive and negative impact]

    - What could be done to minimise any negative impacts on this workforce? Anything else?

17. What impact do you think the Enhanced Service Delivery Model will have on Food Services Staff? Anything else?

    [Probe for positive and negative impact]

    - What could be done to minimise any negative impacts on this workforce? Anything else?

18. What changes to do think need to be made to current models of care to accommodate the Enhanced Service Delivery Model? Anything else?

Model role description (30 minutes)

[Distribute Allied Health Assistant Position Description Template and Scope of Practice for Nutrition and Dietetics]

Group Work Task Two

- Groups of four to five participants

- Participants asked to work collaboratively with their group members to come up with a model role description for Nutrition and Dietetic Assistant, taking into account Enhanced Service Delivery Model.

- Group spokesperson reports lists back to the larger group, and answers are discussed.

19. Thinking about what we have been discussing today, what clinical tasks do you think should be included in the Scope of Practice for Nutrition and Dietetic Assistant? Anything else?

    [Probe for role in clinical assessment and clinical judgement]

20. What non-clinical tasks do you think should be included in the Scope of Practice for Nutrition and Dietetic Assistant? Anything else?

21. What skills and training do you think should be mandatory for Nutrition and Dietetic Assistants upon employment? Anything else?

    - And what about desirable skills and training?

22. Which staff do you think should be responsible for supervising and directing Nutrition and Dietetic Assistants? Why do you say that?

    [Probe for clinical and non-clinical supervision]

Workforce Planning and Development Branch, NSW Ministry of Health

Dietitian and Nutrition Assistant Workforce Mapping

Questionnaire for Clinical Dietitians and Assistants – 8 July 2015

Introduction

Thank you for agreeing to complete this short questionnaire. The questionnaire should take no longer than 10-minutes to complete.

This research is being conducted to gather information on the NSW Health dietitian and nutrition assistant workforce, which will be used to improve the role definition and understanding of the responsibilities undertaken by staff working in these roles.

Your responses will be treated as private and confidential. No individual will be able to be identified from the research results.

Participation is Voluntary

Participation in this research is voluntary, so please feel free to skip any questions that you don't feel comfortable answering. You can also terminate the questionnaire at any time if you wish.

This questionnaire needs to completed no later than **Wednesday 5 August 2015.** We understand that this is a short timeframe and appreciate your help as we know you are busy.

This research is being conducted by Urbis on behalf of the Workforce Planning and Development Branch of the NSW Ministry of Health. If you would like to discuss any aspect of this questionnaire or the information you gave, please contact Tamara Lee on (02) 9391 9803 or talee@doh.health.nsw.gov.au

Screening questions

SQ1.	Are you a…?	Single response
	Clinical Dietitian	1
	Dietitian Assistant	2
	Nutrition Assistant	3
	Diet Aide	4
	Dietitian Technician	5
	Other [Please specify……..]	98

[If SQ1 = 1 go to Question A1; All else go to question C1]

Section A: Dietitian - Training, Role and Supervision

A1.	**Do you currently work with any Dietitian and Nutrition Assistants?** **For the purposes of this survey, please include Diet Aides and Dietitian Technicians**	**Single response**
	Yes	1
	No	2
	Don't know/ not sure	99

[If A1 = 1 go to Question A1.1; all else go to question A4]

A1.1	**How many of the Dietitian and Nutrition Assistants that you work with are employed by HealthShare?** **Please provide number of staff, not FTEs. Just give your best guess if you are unsure. Please include Diet Aides and Dietitian Technicians in the number you provide**	**Open response**
✍		

A1.2	**How many of the Dietitian and Nutrition Assistants that you work with are employed by a LHD?** **Please provide number of staff, not FTEs. Just give your best guess if you are unsure. Please include Diet Aides and Dietitian Technicians in the number you provide**	**Open response**
✍		

A2.	**How often do you provide formal or informal clinical supervision to the Dietitian and Nutrition Assistants that you work with ?** **Clinical supervision is a process of professional support and learning which allows the Dietitian and Nutrition Assistant to develop the knowledge and skills required to enhance the quality and safety of patient care (e.g. providing feedback about a patient's nutrition care plan)**	**Single response**
	Never	1
	Rarely	3
	Sometimes	4
	Often	5
	Very often	6

	Don't know/ not sure	99

A3.	Thinking about the Dietitian and Nutrition Assistants that you work with, how much time in their shift is typically spent performing CLINICAL TASKS? CLINICAL TASKS are tasks directly related to patient care and treatment (e.g. malnutrition screening, application of clinical nutrition/therapeutic diet protocols etc.)									Single response
0	1	2	3	4	5	6	7	8	9	10
Less than 10%	10%	20%	30%	40%	50%	60%	70%	80%	90%	They only perform clinical tasks

A4.		How important do you think it is for Dietitian and Nutrition Assistants to receive…										Single response, Randomise order
		0 Not at all important	1	2	3	4	5 Neutral	6	7	8	9	10 Extremely important
A4.1	Informal, on-the-job training	0	1	2	3	4	5	6	7	8	9	10
A4.2	In-service training	0	1	2	3	4	5	6	7	8	9	10
A4.3	Formal qualifications (e.g. Certificate III or IV in Dietetic Assistance)	0	1	2	3	4	5	6	7	8	9	10
A4.4	Regular interaction with a Clinical Dietitian	0	1	2	3	4	5	6	7	8	9	10
A4.5	Opportunity for formal clinical supervision from a Clinical Dietitian	0	1	2	3	4	5	6	7	8	9	10

A5.	Below are some statements about Dietitian and Nutrition Assistants. For each statement, please indicate whether you agree or disagree.					
	Single response, Randomise order	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
A5.1	Dietitian and Nutrition Assistants should be effective communicators	1	2	3	4	5
A5.2	Dietitian and Nutrition Assistants should possess a demonstrated understanding of therapeutic	1	2	3	4	5

	diets					
A5.3	Dietitian and Nutrition Assistants should possess a demonstrated understanding of food hygiene matters	1	2	3	4	5
A5.4	Dietitian and Nutrition Assistants should possess a demonstrated understanding of general nutrition matters	1	2	3	4	5
A5.5	Dietitian and Nutrition Assistants can contribute to positive patient outcomes	1	2	3	4	5
A5.6	Dietitian and Nutrition Assistants can free up Dietitians to undertake more clinically complex tasks	1	2	3	4	5

A6.a	**To what extent do you agree or disagree that each of the following CLINICAL TASKS should be included in the Scope of Practice for Dietitian and Nutrition Assistants?** **CLINICAL TASKS are tasks directly related to patient care and treatment (e.g. malnutrition screening, application of clinical nutrition/therapeutic diet protocols etc.**						**Single response; randomise order**
		Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Don't know/ not applicable
A6.1	Assist with Dietetic program as directed by the supervising Clinical Dietitian	1	2	3	4	5	99
A6.2	Participate in risk screening including malnutrition screening and other relevant screening programs	1	2	3	4	5	99
A6.3	Identify and report factors that place patients at nutritional and hydration risk (e.g. low appetite, nausea, poor fitting dentures, frailty, etc.)	1	2	3	4	5	99
A6.4	Facilitate access to food and fluids (e.g. opening packs, feeding patients etc.)	1	2	3	4	5	99
A6.5	Apply clinical nutrition/therapeutic diet protocols as delegated	1	2	3	4	5	99

A6.6	Assist the Clinical Dietitian with implementation and monitoring of prescribed nutrition care plans, including discharge planning	1	2	3	4	5	99
A6.7	Facilitate and monitor food orders to Patient Food Services	1	2	3	4	5	99
A6.8	Manage and coordinate the ordering of enteral feeds, commercial oral supplements and infant feeding formulas	1	2	3	4	5	99
A6.9	Assist with nutritional support for patients with dysphagia	1	2	3	4	5	99
A6.10	Communicate with other necessary health service personnel regarding patient diet requirements	1	2	3	4	5	99
A6.11	Support the provision of basic nutrition advice/education	1	2	3	4	5	99

A6.b	**Please list any other CLINICAL TASKS that you think should be part of the Scope of Practice for Dietitian and Nutrition Assistants?** **CLINICAL TASKS are tasks directly related to patient care and treatment (e.g. malnutrition screening, application of clinical nutrition/therapeutic diet protocols etc.).**	**Open response**
	✍	
	✍	
	✍	
	✍	
	✍	

A7.	**To what extent do you agree or disagree that Dietitian and Nutrition Assistants should be responsible for taking patient meal orders?**	**Single response**
	Strongly disagree	1
	Disagree	2
	Neither agree nor disagree	3
	Agree	4
	Strongly agree	5

	Don’t know/ not sure	99

[If A7 = 4/5 go to Question A8; If A7 = 1/2 go to Question A9; All else go to question A10]

A8.	Why do you think Dietitian and Nutrition Assistants should be responsible for taking patient meal orders?	Open response
✍		

[Go to question A10]

A9.	Why do you think Dietitian and Nutrition Assistants should not be responsible for taking patient meal orders?	Open response
✍		

A10.	Are the Dietitian and Nutrition Assistants employed in your Nutrition and Dietetics Department/s involved in nutrition risk assessment?	Single response
	Yes	1
	No	2
	The Department/s I work in do not employ Dietitian and Nutrition Assistants	3
	Don’t know/ not sure	99

[If A10 = 1 go to Question A11; all else go to question B1]

A11.	Please briefly describe the role that Dietitian and Nutrition Assistants currently play in nutrition risk assessment in your workplace.	Open response
✍		

Section B: Dietitian – Demographics

B1.	How old are you?	Open response
	16-24 years old	1
	25-34 years old	2
	35-44 years old	3
	45-54 years old	4
	55-64 years old	5
	65 years or older	6
	I'd prefer not to say	98

B2.	Are you a….?	Single response
	Male	1
	Female	2
	I'd prefer not to say	98

B3.	For how many years have you been practicing as a Clinical Dietitian?	Single response
	Less than two years	1
	3-5 years	2
	6-10 years	3
	More than 10 years	4
	I'd prefer not to say	98

B4.	What is the highest level of formal education that you have completed?	Single response
	Under Year 10	1
	Year 10 or equivalent	2
	Year 11 or equivalent	3
	Year 12 or equivalent	4
	TAFE, diploma, certificate	5
	Undergraduate university degree	6
	Post-graduate university degree	7
	Other [Please specify……..]	8

	I'd prefer not to say	99

B5.	**In which hospital or hospitals do you work?** *If you would prefer not to say or are not sure, please leave blank.*	**Open response**
✍		

B6.	**Are you employed by…?**	**Open response**
	LHD/ Speciality Network	1
	Health Share	2
	Other [Please specify……..]	3
	Don't know/ not sure	99

Thank you for taking the time to complete this questionnaire.

This research is being conducted by Urbis on behalf of the Workforce Planning and Development Branch of the NSW Ministry of Health. If you would like to discuss any aspect of this questionnaire or the information you gave, please contact Tamara Lee on (02) 9391 9803 or talee@doh.health.nsw.gov.au

Section C: Assistants – Training, Role and Supervision

C1.		Thinking about the skills required to perform your current role successfully, how useful is…?										Single response, Randomise order
		0 Not at all useful	1	2	3	4	5 Neutral	6	7	8	9	10 Extremely useful
C1.1	Informal, on-the-job training	0	1	2	3	4	5	6	7	8	9	10
C1.2	In-service training	0	1	2	3	4	5	6	7	8	9	10
C1.3	Formal qualifications (e.g. . Certificate III or IV in Dietetic Assistance)	0	1	2	3	4	5	6	7	8	9	10
C1.4	Regular feedback from a Clinical Dietitian	0	1	2	3	4	5	6	7	8	9	10

C2.	**What is the position title of your current supervisor?** **Your supervisor is the person responsible for organising your roster, approving shift changes, assigning tasks, etc.**	Single response
	Dietitian	1
	Diet Supervisor	2
	Catering Supervisor	3
	Catering Manager	4
	I don't have a supervisor	5
	Other [Please specify……..]	6
	Don't know/ not sure	99

C3.	**How often do you communicate with staff from Patient Food Services during a typical shift?**	Single response
	No contact	1
	1-5 times per shift	2
	6-10 times per shift	3
	11-20 times per shift	4
	More than 20 times per shift	5
	Don't know/ not sure	99

[If C3 = 2/3/4/5 go to Question C4; all else go to question C5]

C4.	What are the most common reasons for your communication with Patient Food Services?	Open response
✍		

C5.	How often do you perform each of the following CLINICAL TASKS? CLINICAL TASKS are tasks directly related to patient care and treatment (e.g. malnutrition screening, application of clinical nutrition/therapeutic diet protocols etc.)						Single response; randomise order
		Never or very rarely	Once a month	Once a week	One to five times per shift	More than five times per shift	Don't know/ not applicable
C5.1	Assist with Dietetic program as directed by the supervising Clinical Dietitian	1	2	3	4	5	99
C5.2	Participate in risk screening including malnutrition screening and other relevant screening programs	1	2	3	4	5	99
C5.3	Identify and report factors that place patients at nutritional and hydration risk (e.g. low appetite, nausea, poor fitting dentures, frailty, etc.)	1	2	3	4	5	99
C5.4	Facilitate access to food and fluids (e.g. opening packs, feeding patients etc.)	1	2	3	4	5	99
C5.5	Apply clinical nutrition/therapeutic diet protocols as delegated	1	2	3	4	5	99
C5.6	Assist the Clinical Dietitian with implementation and monitoring of prescribed nutrition care plans, including discharge planning	1	2	3	4	5	99
C5.7	Facilitate and monitor food orders to Patient Food Services	1	2	3	4	5	99
C5.8	Manage and coordinate the ordering of enteral feeds, commercial oral supplements and infant feeding formulas	1	2	3	4	5	99
C5.9	Assist with nutritional support for patients with dysphagia	1	2	3	4	5	99
C5.10	Communicate with all necessary other health service	1	2	3	4	5	99

	personnel regarding patient therapeutic diet requirements						
C5.11	Support the provision of basic nutrition advice/education	1	2	3	4	5	99

C6.	**Please list any other CLINICAL TASKS that you currently perform as part of your role.** **CLINICAL TASKS are tasks directly related to patient care and treatment (e.g. malnutrition screening, application of clinical nutrition/therapeutic diet protocols etc.).**	**Open response**
	✍	
	✍	
	✍	
	✍	
	✍	

C8.	**How much time in a typical shift is spent performing clinical tasks?** **CLINICAL TASKS are tasks directly related to patient care and treatment (e.g. malnutrition screening, application of clinical nutrition/therapeutic diet protocols etc.)**									**Single response**
0	1	2	3	4	5	6	7	8	9	10
Less than 10%	10%	20%	30%	40%	50%	60%	70%	80%	90%	I only perform clinical tasks

C9.	**How often do you perform each of the following NON-CLINICAL TASKS ?**						**Single response; randomise order**
		Never or very rarely	Once a month	Once a week	One to five times per shift	More than five times per shift	Don't know
C9.1	Book appointments	1	2	3	4	5	99
C9.2	Collect data for monitoring, quality improvement or statistical purposes	1	2	3	4	5	99
C9.3	Assist with ordering and/or purchasing of supplies and materials including stationary, stock and non–stock items	1	2	3	4	5	99

C9.4	Administrative duties – word processing, telephone duties, photocopying, monitor resource usage, laminating,	1	2	3	4	5	99
C9.5	Assist in the identifying and ordering of equipment and resources as delegated by your supervisor	1	2	3	4	5	99
C9.6	Participate in LHD performance management processes (e.g. performance appraisal)	1	2	3	4	5	99
C9.7	Plate meals	1	2	3	4	5	99
C9.8	Deliver meal trays to patients	1	2	3	4	5	99
C9.9	Collect meal trays from patients	1	2	3	4	5	99
C9.10	Wash dishes (e.g. pack dishwasher)	1	2	3	4	5	99
C9.11	Check trayline						

C10.	**Please indicate any other NON-CLINICAL TASKS that you currently perform as part of your role.**	**Open response**
	✍	
	✍	
	✍	
	✍	
	✍	

Section D: Assistants – Demographics

D1.	How old are you?	Open response
	16-24 years old	1
	25-34 years old	2
	35-44 years old	3
	45-54 years old	4
	55-64 years old	5
	65 years or older	6
	I'd prefer not to say	98

D2.	Are you a….?	Single response
	Male	1
	Female	2
	I'd prefer not to say	98

D3.	Please indicate which of these courses you have completed or are currently completing.	Multi response			
		Yes, completed	Yes, currently completing	No	Don't know
	Dietary Practices Certificate	1	2	3	99
	Certificate III in Health Service Assistance (Nutrition and Dietetics)	1	2	3	99
	Certificate III in Allied Health Assistance				
	Certificate IV in Allied Health Assistance	1	2	3	99
	Other relevant qualification [Please specify……..]	1	2	3	99

D4.	What is the highest level of formal education that you have completed?	Single response
	Under Year 10	**1**
	Year 10 or equivalent	**2**
	Year 11 or equivalent	**3**
	Year 12 or equivalent	**4**
	TAFE, diploma, certificate	**5**
	Undergraduate university degree	**6**

	Post-graduate university degree	**7**
	Other [Please specify……..]	**8**
	I'd prefer not to say	**99**

D5.	**In which hospital or hospitals do you work?** *If you would prefer not to say or do not know, please leave blank.*	**Open response**
✍		

D6.	**Are you employed by…?**	**Open response**
	LHD/ Speciality Network	1
	Health Share	2
	Other [Please specify……..]	3
	Don't know/ not sure	99

Thank you for taking the time to complete this questionnaire.

This research is being conducted by Urbis on behalf of the Workforce Planning and Development Branch of the NSW Ministry of Health. If you would like to discuss any aspect of this questionnaire or the information you gave, please contact Tamara Lee on (02) 9391 9803 or talee@doh.health.nsw.gov.au

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