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build trust and rapport with the community. Building up trust and maintaining confidentiality is critical. A visit usually involves talking to the women, sharing stories, laughter and a meal, making sure that there are other activities, for example crafts and arts are available for the women, to be part of the proceedings. Sometimes we have a community barbecue following the health promotion and education sessions; all of the community is invited along as we do not know when some of the community people, including children, might have had something to eat. We cannot be feeding some of the community and not others, this is not our way.

When non-Aboriginal women are trained to be nurse practitioners within their health service, the wider community accepts the workers in their roles. In our communities, it is more complicated. Just because a non-Aboriginal person has been appointed to work in the community health service with our women does not mean that they are culturally appropriate to work in this setting. It will be up to the community whether you will be accepted into the community, depending on your attitude toward community people, cultural awareness, and ability to listen and hear what is being said. It does not matter if you are a doctor or a nurse, if the community does not accept you because of some of the reasons stated above, then they will not come along to the clinic.

When delivering health promotion and education sessions, we make sure that the information is presented in a culturally sensitive way. We do not make the women shame. Within our information sessions we not only talk about well women's screening, we include other women's health issues. If we only talked about well women's screening then we would not get anyone to come along as this is a shame job.

When developing resources for communities we need to make sure that the women involved are culturally appropriate and have an understanding and respect for the culture. Materials produced must be easy for community women to understand. We do this by removing the jargon and making the resource relevant to the community, by consulting with and working with Aboriginal women, Aboriginal health workers and organisations throughout the whole process. This way it is community driven and community owned.

Sharon Clarke has already produced a women's video after consulting extensively with community women, Aboriginal health workers and both Aboriginal and non-Aboriginal health services, around South Australia, who provide service delivery to Aboriginal and Torres Strait Islander women, including well women's checks.

At the national level the Commonwealth Department of Health and Ageing and the Aboriginal and Torres Strait Islander Women's Forum intend to develop a national colposcopy video/dvd for Aboriginal and Torres Strait Islander women, with a second more detailed video/dvd for use as a training tool for Aboriginal health workers.

This is our story and it is not to be used as guidelines on how to work within our communities.

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**NUTRITIONAL SCREENING FOR OLDER PEOPLE – A CAPACITY BUILDING APPROACH THAT TARGETS IMPROVEMENT OF NUTRITIONAL HEALTH FOR OLDER AUSTRALIANS THROUGH SERVICE REORIENTATION**

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**Introduction**  

Australia has an ageing population and restoring or maintaining the health of older people is an ongoing issue. Nutrition and physical activity are the two main areas identified by the World Health Organisation (WHO) for prevention of chronic disease burden and improving healthy ageing. Identification of nutritionally vulnerable older people is crucial to early intervention to improve health.

Poor nutrition can lead to an increased risk of falls, fractures and infections, poor wound healing, poor recovery from surgery, and longer hospital stays. As well, poor nutrition may lead to decreased appetite, dental problems, depression, apathy and even dementia. Protein-energy malnutrition can be a cause of weight loss when present with other factors such as cancer, chronic airways disease, Alzheimer’s, Parkinson’s, diabetes, depression and the use of particular medications. Nutritional risk factors in older people are acute or chronic disease, polypharmacy and social isolation. Nutritional intervention is proven to be beneficial in these settings.

A recent study by one of our group developed and validated a simple screening procedure which provided a quick and inexpensive method of identifying older people who are at risk of undernutrition. The study also indicated that undernutrition among sub-acute care patients was high and that patients who were undernourished had significantly worse
discharge outcomes than their well nourished counterparts.\textsuperscript{5} Research with community based elderly clients found that use of a nutritional screening process by health workers identified 38.4\% of clients to be at risk of malnutrition and these people had significantly worse outcomes than well nourished people when followed up at 12 months.\textsuperscript{6}

There is evidence that nutritional intervention can extend the years of healthy life for older people.\textsuperscript{7} Evidence also exists that identifying and planning assistance for home based older people requires a multidisciplinary approach to prevention to maximise the efforts of service providers through a focus on leadership, effective communication and the maintenance of functional alliances.\textsuperscript{2}

An Adelaide based project has been working with a collective of aged care centered organisations to improve the nutritional health of older people through identifying and addressing nutritional risk. This has involved working with the collective to reorient services, within existing funds, to prioritise nutrition by including screening and early intervention for poorly nourished or nutritionally at-risk older people. Objectives centered on developing workforce capacity through increased awareness and the use of an early intervention strategy. The project proposed to increase collaborative activity toward health improvement.

A capacity building approach
Capacity building is a recognised method of organisational development and of health promotion, and has been extensively detailed in Australia.\textsuperscript{8} Hawe et al promote capacity building as an approach which will support “the development of sustainable skills, structures, resources and commitment to health improvement in health and other sectors to prolong and multiply health gains many times over.”\textsuperscript{9}

The Healthy Ageing – Nutrition project used this approach in working with organisations to develop their capacity to screen older people for nutritional risk and to develop or improve strategies for intervention in cases where risk is identified. Five elements of capacity building were used to categorise the types of activity that the project’s partnering groups and organisations have undertaken. These were:

- organisational development
- workforce development
- resource allocation
- partnerships
- leadership.

A further category, “policy development”, was added to describe changes that were incorporated into policy within organisations and in other settings.

Each participating organisation or group was offered printed material and a follow-up discussion on capacity building concepts to assist with planning change toward the project’s objectives, including increasing the use of simple screening and assessment tools. Provided documents offered examples of strategies that could be used to influence each of the capacity building elements.

The partnering organisations came from different aspects of care to clients within the aged care sector and had different perspectives on nutritional care for older people. Six of the Ten partnering organisations employed more than 100 staff.

A residential care facility, a support agency for family carers, a home nursing service, two organisations involved in meal preparation and delivery services (one focused on the general community and the other associated with several ethno-specific meal services) were project partners. A sub-acute care facility, a domiciliary care service, divisions of general practice and an organisation providing physical activity programs to older people also partnered the project. Additionally, a group of dietitians with an interest in aged care met regularly during the project as a quasi-organisation.

Project methods
An action research framework\textsuperscript{10} was adopted and action plans were developed by each participating group and agreed in conjunction with project staff. Action plans were negotiated with some for 12 months and others for shorter periods. These were continually reflected on as action towards the planned approaches evolved.

The action research framework provided an opportunity for a diversity of groups and organisations with a common problem (identifying and addressing nutritional risk among clients) to collaborate in planning, implementation and ongoing reflection and evaluation. It assisted in identifying new, collective and complementary knowledge and putting it into practice toward common solutions, thus building system capacity.

The benefit of this problem-solving approach is that it allowed the partner organisations to recognise and take advantage of existing knowledge and skills; it offered flexibility of design to accommodate different settings and different needs of workers and clients, and it helped to promote commitment to overall process by providing the opportunity for individualising of approaches to change. This then encouraged ownership of outcomes. All organisations were followed for 12 months and took part in extensive formative and summative evaluation conducted by an external evaluator.

Screening
At the commencement of the Healthy Ageing – Nutrition project, widespread use of general assessment tools, including a nutrition component or specific nutrition assessment and intervention tools in South Australia, was not found. It could be anticipated, though, from available evidence that many older people live with malnutrition or with significant nutritional risk.

Each group or organisation connected to the project has a different client base and a different relationship with its client groups. Each also had a set of unique and highly developed
values embedded in organisational or workforce culture. This meant that no single screening tool was applicable for use in the project. Identification of a raft of existing, validated tools was carried out by both project staff and its partners and a variety of tools were adopted, and sometimes adapted, to the specific needs of the organisations.

Through an action research approach it was possible to develop an environment in which organisations, groups and individuals could participate in developing solutions to screening and intervention in conjunction with the project while exploring, discussing and purposefully accepting or changing their own biases and preferences.

Inclusiveness and acceptance of choice of screening tools was essential to the project’s progress. Depending on their own context, some organisations used client-focused self-screening tools such as that produced by the American Academy of Family Physicians Nutrition Screening Initiative. Others used “spotter guides” based on components of validated screening tools to assist volunteer workers to identify and report risk factors. Some organisations only used formally recognised and validated tools such as rapid screen, the Mini-Nutritional Assessment (MNA) or the Nutritional Risk Screening and Monitoring Tool, applying these as their designers had intended. In some cases, combinations of formal and informal tools were used, building on findings reported to general practitioners, such as work by Visvanathan and Newbury et al.

According to external evaluation of the project, seven of the case study organisations have changed their nutritional assessment practices and have introduced screening tools. This was accompanied by other activity such as policy development in the organisation, training for workers and planning of processes to audit the use of screening. In addition to these seven organisations, three other organisations (not directly providing organisation-based services to clients) have provided tools and support to their associates to support screening and early intervention.

**Results**

Of the 10 partnering organisations, all reported benefits of being involved in a health focused capacity building project. The majority of organisations (7/10) commenced screening and early intervention programs for nutritional risk where no systematic approach had previously been enacted. Actions varied depending on the organisation’s focus. In the sub-acute care, general practice and residential care settings, the focus was on screening and assessment using a simple tool, followed by further comprehensive assessment and intervention which was likely to include referral to secondary sources of care.

The meal-service settings, the family carers group and the physical activity organisation were more likely to report increased awareness of risk factors and referral back to care coordinators, case managers and other care providers such as the client’s general practitioner. Eight of the Ten organisations reported an increased awareness in the workforce of ageing and nutrition issues and risks.

Organisations frequently reported sharing information and resources with other organisations in their network (sometimes developing their networks for this purpose through the project). This had the effect of increasing intersectoral collaboration towards reorientation of the services provided and was viewed by project partners as a positive aspect of the capacity building approach of the project.

Factors identified as enablers of change by the project’s partners were categorised into two areas. From the project, enablers included facilitation, support, leadership, the provision of information and resources from the project to the organisations and the project’s acceptance of organisational goals and values. From the organisations themselves, enablers included support from the organisation’s board and/or management, previous work or interest in the topic, flexibility to take on a new role by workers and decision makers, having a change agent or quality improvement process in the organisation, and seeing the project as relevant and adding value to the organisation’s current work.

Barriers to change were identified to include lack of time and resources within organisations and that participation in the project added to the workload (for 8/10). Resistance to change and specific organisational factors such as lack of a change champion, frequent changes in staff, lack of a quality improvement culture and no clear motivation for change were also mentioned.

**Conclusion**

In this project a capacity building approach was used and was effective (verified by external evaluation) in bringing about organisational change which supported the project’s objectives. The capacity building approach increased awareness of the nutritional needs of older people, increased use of nutritional screening tools, and increased interventions of at-risk individuals. The approach was effective in building links between organisations and services which lead to collaborative activity and broader system improvement.

The action research framework allowed the project to value a diverse range of approaches to change, avoiding alienating organisations which are shaped or constrained by culture, finance, staffing or other factors that may otherwise have inhibited change. Organisational change will sustain changes long after the initial project intervention.

Capacity building provided a very cost effective means of facilitating improvement. It requires very little additional external human capital and only a small amount of funding for forums, workshops and communication to be successful.
References


SCREENING SOUTH AUSTRALIAN NEWBORNS FOR HEARING IMPAIRMENT

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Background

In November 2004, Lea Stevens, then Minister for Health in the South Australian Government, commissioned the Children Youth and Women’s Health Service to implement a program of hearing screening for neonates. The aim was so that by the end of 2005 every infant born in South Australia would be screened for hearing impairment within a few days of birth.

At the time, eight hospitals in the state were already screening the hearing of close to one-third of South Australian newborns. Five of these hospitals, some metropolitan, some rural, some public, some private, had been participating in a pilot program since 2002. An intense period of state-wide planning, recruitment, purchases, negotiations and training followed promptly upon the Minister’s request. The outcome was that by the end of January 2006 the program of Universal Newborn Hearing Screening (UNHS) had reached all of the state’s birthing units, and was indeed available to every newborn. The only exception, at that time, was unplanned deliveries in remote Indigenous communities.

There has been increasing evidence to support the common observation of teachers that deaf and hearing impaired children acquire language skills more readily if their impairment is recognised in infancy and appropriate intervention is commenced from a very early stage, preferably as early as age six months.\(^1,2\) Better language acquisition begets healthier family and social relationships, with less reliance on special education provision in childhood and social services in adulthood. The only effective means of detecting hearing impairment in a population at such a young age is through a screening program employing objective physiological measurements. Suitable techniques, namely measurement of otoacoustic emissions (OAE) and automated measurement of the auditory brainstem response (AABR), have been available and used in screening programs since 1990.\(^3,4\)

Prevalence of hearing impairment

Estimates of the prevalence of permanent childhood hearing impairment (PCHI) vary widely, dependent partly on definition. Conventionally, “significant” PCHI is understood to mean a bilateral impairment of moderate degree (40dB) or greater, a level of impairment likely, without intervention,