Australian Government
Department of Health and Ageing

hacc
home and community care

Meeting the Cultural Food Needs of Queensland's Culturally and Linguistically Diverse (CALD) Aged: What Do Service Providers Say?

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Queensland University of Technology for Diversicare

August 2012

QUT

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Caring For People

Ethnic Communities Council of Queensland

HACC is a joint Australian Government-State funded program.

Diversicare

Diversicare is the community care division of the Ethnic Communities Council of Queensland (ECCQ). Diversicare manages special projects and service development relating to ethic aged care in Queensland including Home and Community Care (HACC) Multicultural Advisory Service (statewide), Partners in Culturally Appropriate Care (PICAC) (statewide), Community Partners Program (CPP) (Brisbane, West Moreton and Sunshine Coast Regional Councils), National Prescribing Service (NPS), community information sessions for Spanish-speaking and Vietnamese communities (Brisbane and the Gold Coast) and the Community Visitors Scheme (CVS) (statewide). Diversicare is also a member of the mhWISE (Mental Health and Wellbeing of Older Persons) Consortium.

These programs, excluding CVS, provide education and information services to people from culturally and linguistically diverse (CALD) backgrounds and to aged care service providers, their clients and carers. Through collaboration with formal and informal ethnic community organisations, groups and individuals, aged care providers, and other related programs (for example those dealing with torture and trauma, elder abuse, dementia, palliative care, continence services), Diversicare's programs and services work to enhance the capacity of aged care and HACC service providers to provide holistic culturally appropriate care to CALD clients.

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This project was funded by the Queensland Department of Communities, Home and Community Care program, who have engaged Diversicare to undertake work in meeting the food needs of Queensland's ageing CALD community. This work was carried out in conjunction with QUT School of Public Health.

Disclaimer

Although funding for this project has been provided by the Australian Government, the material contained herein does not necessarily represent the views or policies of the Australian Government.

Acknowledgments

We would like to sincerely thank the key stakeholders and HACC service providers who kindly agreed to participate in this research. The insights, intelligence and time that you provided have facilitated the creation of this report which aims to guide improvements in HACC food services for all Queenslanders.

We would also like to thank Mangol Lok, Diversicare, for his assistance in recruiting participants and consultation throughout the research process.

Finally, we wish to extend our appreciation to the reviewers of this report: Julie Fraser, Taryn Quach, Mangol Lok and Debra Tape.

Suggested citation: Millichamp, A & Gallegos, D. 2011. *Meeting the Food Needs of Queensland's Culturally and Linguistically Diverse (CALD) aged: What do service providers say?* Brisbane: Queensland University of Technology.

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Glossary, definitions and acronyms

Definitions

Aged **Older people**	Aged and older people are used interchangeably to refer to people aged 65 years or older, unless otherwise specified.
Culturally and Linguistically Diverse (CALD)	Culturally and linguistically diverse is a term used to capture people who were born in a country outside of Australia, whose language and/or culture are different to that which dominates in Australia.
Emerging communities	Groups which comprise small numbers in one population centre, who may have non-existent or weak support structures, lack extensive family networks and/or do not have experience and familiarity with government and mainstream services[4].
Net Overseas Migration	Comprised of offshore arrivals under the permanent migration and humanitarian programs, temporary long stay migrants (e.g. students) and subclass 457 skilled workers, as well as the movement of Australian residents and New Zealand citizens[5].
Non-English Speaking Background	People who speak a language other than English as their native tongue.

Acronyms

ABS	Australian Bureau of Statistics
CACP	Community Aged Care Package
CALD	Culturally and linguistically diverse
EACH	Extended Aged Care at Home
EACH-D	Extended Aged Care at Home - Dementia
HACC	Home and Community Care
MDS	Minimum Data Set
MOW	Meals on Wheels
NESB	Non-English Speaking Background
ONI	Ongoing Need Identification Tool

Executive Summary

This report summarises research undertaken by Queensland University of Technology, Brisbane, in partnership with Diversicare, on *'Meeting the cultural food needs of Queensland's Culturally and Linguistically Diverse (CALD) aged'*. An earlier literature review[6] summarised the state of the evidence in relation to Australia's CALD aged population and their less than optimal usage of Home and Community Care services (HACC), in particular, food services. This report builds on the information presented in the literature review aiming to explore the current provision of food services to CALD clients and the barriers and enablers to this service provision in Queensland.

Two research activities were conducted with HACC aged care service providers in Queensland. The initial activity involved conducting in-depth semi-structured interviews with key informants from a range of HACC aged care services to gain insight into the provision of HACC food services to CALD clients. Following this, an online survey was sent to 280 HACC service providers across Queensland aiming to ascertain the cultural profiles of service clientele, food service practices, cultural sensitivity of food service practices, perceived barriers and enablers to achieving culturally appropriate food services, client assessment practices, perceived benefits to the service and clientele that would be achieved from offering culturally appropriate food services and strategies that would likely be of greatest assistance in delivering culturally appropriate food services. Responses have been considered in light of the recent announcement of Aged Care Reforms that are to be undertaken across Australia.

Whilst participation in the online survey was poor, with just 26 respondents, when combined with the detailed data obtained in the key stakeholder interviews, consistent themes and patterns emerged facilitating exploration of barriers and enablers to achieving culturally appropriate HACC food services. The data also enabled investigation into existing service issues and exemplified the urgent need for further work in this area of significant importance to wellbeing.

Evidence suggests that whilst there are some CALD groups whose cultural food needs are being met by HACC aged care services; there remain multiple CALD groups in Queensland who do not have adequate access to culturally appropriate HACC food services. For example, there are no Halal, Vietnamese, Chinese, Italian, Spanish, Pacific Islander (PI) or Maori delivered meal services in Queensland, despite large numbers of CALD aged in these communities. Although food services do

not attract the greatest share of HACC funding, eating is an essential daily activity that is capable of providing not only nourishment with significant clinical gains, but also enjoyment, social engagement and improved quality of life. Whilst there may be a perceived lack of demand for HACC food services by some CALD communities associated with cultural norms for aged care, there also appeared to be a common assumption that CALD families have the capacity to provide ongoing food services when required. This assumption however, is not appropriate as it burdens families and creates disparities in care provision. An ecological view would consider that the decision to take up HACC food services is influenced by the availability, or lack thereof, of culturally appropriate services, in addition to individual preferences and circumstances.

There appeared to be a poor understanding of the cultural food needs and preferences of some HACC services' catchment areas related to limited data collection. It is vital that more information relating to the cultural food preferences of Queensland's CALD elderly is consistently collected in an organised and formal manner. Application of a universal cultural food preference assessment tool will facilitate the collection of such information, alongside change management processes at the organisational level involving training volunteers, staff and management in handling and responding to such data.

Unfortunately in Queensland, the most widely available delivered food service, Meals on Wheels (MOW), was seen by many participants to not meet cultural food needs for the majority of CALD elderly. For MOW specifically, low levels of funding (obtained through the HACC meal subsidy of $2.50 per meal), the unique organisational structure, co-existence of diverse production methods, reliance on volunteers (including the fact that volunteers may lack appropriate skills to meet cultural food preferences), lack of awareness of and/or reluctance to utilise commercial meal providers that can provide culturally appropriate meals, low levels of cultural awareness and appropriate training were major perceived barriers to meeting the cultural food needs of Queensland's CALD elderly. Furthermore, logistical issues associated with the heterogeneity of CALD aged and their associated food preferences (e.g. preferring centre-based meals, fresh cooked or hot delivered meals), service needs and cultural/religious food requirements, are not insignificant and present challenges to HACC food services. Another logistical issue relates to the diversity of food service systems in operation across the many HACC food services.

Looking to solutions on how to provide culturally appropriate food services to all Queenslanders, it is possible that changes will need to be made incrementally to allow systems and organisations to adapt and find solutions that are acceptable to stakeholders. Input from CALD communities will be important in assisting the delivery of culturally appropriate food to CALD elderly – this includes input in the form of guidance on what to cook and how, providing volunteers from CALD communities and promotion within CALD communities. Additional funding for infrastructure, administration and day-to-day operational costs is also seen as important for helping HACC services meet cultural food needs in the future. Increased linkages between HACC food services and other HACC services, and between HACC food services themselves, particularly those services engaged in CALD communities, will be of benefit in improving the ability of MOW to adapt to meet cultural food preferences.

Nutrition risk screening is most often carried out at initial assessment as part of the Ongoing Needs Identification (ONI) assessment tool, a tool utilised by HACC service providers to assess the needs and eligibility of clients. HACC food services are not required to complete the ONI. Our findings indicate that HACC food services do not conduct regular, formal nutrition screening, relying instead on informal observation and conversation. Delivered meal services and in-home care/meal preparation provides frequent contact between volunteers and clients making them well placed to carry out nutrition risk screening. This would require volunteers to receive appropriate training and support to carry out the new responsibility.

Many participants saw clear benefits from delivering culturally appropriate food services to clients. These benefits flowed not only to the clients, but to the organisations themselves and included benefits such as, increased client satisfaction and nutritional status, improved community cohesion and engagement, staff/volunteer skill development and increased morale and importantly, increased enjoyment of meals by clients.

Based on these findings, key recommendations include:

- Review of Meals on Wheels Services in Queensland including:
- **The structure of delivered meal services in Queensland** with the aim of increasing accountability and standardizing food and nutrition quality.
- **The model of delivered meal service provision** to improve access and acceptability of services across a broad spectrum of geographical, personal and cultural needs.
- **The funding model for delivered meal services** in acknowledgement of rising infrastructure and food costs, as well as potential costs associated with establishing culturally appropriate food services.
- **The collection of a minimum data set be extended and mandated** for all HACC services to include not only age, gender and number of delivered meals, but also to include nutritional risk and food security status.
- Improving the understanding of the needs of and community generated solutions for meeting the cultural food needs of food service recipients is essential to ensure that the system remains responsive and supportive of CALD aged. The minimal, and inconsistent, information that is currently collected makes it difficult, if not impossible, to plan and evaluate existing services. In addition, research needs to be undertaken to explore the barriers and enablers, benefits and costs of delivering culturally sensitive food services. **Further systematic research needs to be undertaken to provide this evidence base.**
- Community consultation and engagement is essential to support the design and delivery of culturally appropriate aged care services to CALD aged. Evidence collected in this research indicates that this is an area where organisations may not feel sure of how to proceed. **Clear guidelines on how organisations can engage CALD communities and implement positive, affordable improvements in the cultural offerings of their menus are required.**

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1 Introduction

The Australian population is increasing in size and is becoming more culturally diverse, but it is also ageing. As a result, overall, there is an increase in the number of aged persons from culturally diverse backgrounds[7, 8]. Elderly people, and especially those from Culturally and Linguistically Diverse (CALD) backgrounds, are identified as being vulnerable with specific health and wellbeing needs[9]. CALD elderly may also face barriers to accessing appropriate aged care services[10, 11]. This has important implications for aged care service delivery and in particular, delivering culturally appropriate services requires careful consideration and planning. In Australia, there are a broad range of aged care services that strive to meet the diverse range of care needs of the elderly population. Within these services there are aged care service organisations that strive to meet the needs of one or more cultural groups. These services are supported by overarching government initiatives such as the Partners in Culturally Appropriate Care (PICAC)[12] and the Community Partners Program (CPP)[13]. Despite these efforts concerns remain that CALD elderly underutilise existing aged care services[14, 15].

The underutilisation of services could have implications for overall health and wellbeing including nutrition. Achieving adequate nutrition is recognised as an important contributor to health[16] with malnutrition in community dwelling aged a public health concern[17]. Unfortunately, little is known about the health and nutrition status or food security status of community dwelling CALD elderly in Australia. However, a recent literature review conducted by the authors of this report indicates that there are potential gaps in the uptake of HACC food services amongst CALD elderly and that there is potentially inadequate provision of meals that are in line with cultural food preferences[6]. In order to investigate these potential gaps this research seeks to explore service provision from the viewpoint of HACC food service providers and key stakeholders.

This report provides background on the ageing CALD population in Australia and Queensland, their nutrition needs and current aged care food services in operation. In addition, it will outline the research aims and methodology; highlight key findings and make recommendations.

1.1 Australia's and Queensland's ageing CALD population

The population in Australia is forecast to grow from 21 million people in 2006 to be between 31 and 43 million people in 2056.[18] As described above, the population of Australia is ageing and the number of elderly people is expected to rise significantly in coming years[18]. Australia's significant CALD population is also ageing[8, 18], with dynamic immigration patterns creating shifts in ethnic composition and increasing cultural diversity of this population as time progresses[19]. As of 2006, the ABS Census indicated that more than 500,000 people or 19% of the population aged over 65 years were born in a CALD country[20], a number that has been projected to increase to more than one million, or 25% of the aged population, by 2026[8]. It has also been estimated, based on 1996 Census data, that by 2011, 22.5% of older Australians and one of every four people aged over 80 years will be from CALD backgrounds[8]. The majority of elderly people live in the community, as opposed to living in residential aged care facilities[19] and a greater proportion live in non-capital cities[21].

Queensland is Australia's third most populous state, with approximately 4.4 million residents in 2009[22]. It is forecast that the 12.4% of the Queensland population aged 65 years or older will increase to 26.1% by 2056[22]. Of Queensland's CALD population, in 2006, 23% were aged 65 years or older[23].

The delivery of appropriate aged care services requires careful planning. It is acknowledged that the consideration of the cultural needs of CALD elderly is essential for planning and developing appropriate aged care services given that CALD elderly are a vulnerable group who may experience a level of relative disadvantage accessing mainstream aged care services[24].

1.2 Aged Care Services and Culture

In Australia, there is a range of aged care services available across a continuum from community-based care to high level residential care, designed to cater for diverse aged care needs. Home and Community Care (HACC) services are community aged care services jointly funded by the national and state/territory governments that are focused on supporting ongoing independence of the elderly to remain living and engaged within their communities in preference to entering residential care[1, 15].

The importance of culture and 'cultural competency' in providing care services is well recognised[24-26]. A culturally competent health care system has been described as *"one that acknowledges and incorporates – at all levels – the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expression of cultural knowledge, and adaptation of services to meet culturally unique needs"*[25, P:293]. Culturally competent care is seen to be a cornerstone of eliminating ethnic disparities in health and wellbeing[25]. In Australia, and Queensland, aged care services exist along a spectrum of cultural specificity ranging from services targeting one or more specific cultural groups, to those which are generic and do not offer any culturally specific/culturally oriented services (but may still service CALD elderly)[24].

A range of barriers exist that can make accessing aged care services more challenging for CALD elderly[11]. These include: poor knowledge of available services, lack of culturally appropriate services, language barriers, poor communication, poor linkages between aged care service providers and CALD groups, and shortage of bilingual employees with appropriate qualifications[27, 28]. National and state/territory governments acknowledge the important role culture plays in influencing aged care needs as demonstrated through enacting relevant policies and creating initiatives that aim to support fair and equal access to all services for Australians, regardless of cultural background or religion.

Two current government initiatives, PICAC and CPP, seek to support the delivery of culturally appropriate aged care by encouraging linkages between aged care providers, CALD communities and the Australia Government Department of Health and Ageing[12, 13]. The PICAC program funds one organisation in each state and territory to assist aged care organisations respond to the unique needs of CALD elderly[12]. In Queensland, the PICAC program is run by Diversicare which is a division of the Ethnic Communities Council of Queensland.

1.3 Culture and the Aged

Nutrition and good health are linked throughout the lifespan[16] with ageing presenting potentially unique challenges to attaining optimal nutrition such as reduced appetite, dentition problems, reduced food variety and swallowing difficulties, amongst others[29]. Food preferences of the elderly are also likely to be impacted by lifetime food habits, migration, living arrangements, financial constraints, reduced transport options, disability[30] as well as social integration and psychological wellbeing[29].

These factors contribute to an increased risk of malnutrition. Poor nutrition or malnutrition amongst the elderly has been associated with increased risk of falling, higher level needs, increased complication rates, more frequent and longer hospitalisations and a reduced capacity to remain living independently[31]. Unsurprisingly, this is also associated with higher healthcare costs[32]. Whilst there is limited data available relating to malnutrition in community dwelling elderly, it is acknowledged as a problem with the malnutrition prevalence having been estimated as being between 10 and 30% (but this is likely to be an underestimate)[17]. While little is known about the malnutrition risk of community dwelling elderly in general[33], even less is known about the malnutrition risk of community-dwelling CALD elderly.

Interactions between food preferences, food selection and nutrition behaviour are complex and driven by multiple determinants[34, 35] Culture has a significant impact on food selection and food preferences[36]. It has been suggested that elderly people may express greater preference for the foods of their traditional culture[37] however it is acknowledged that the experience of immigration[38, 39] and degree of dietary acculturation[35, 40, 41] to the host culture are also important considerations when considering food preferences and nutritional status of the elderly. Food and nutrition services that consider cultural preferences have therefore been identified as important components of the continuum of care[16].

1.4 HACC Program and Cultural Diversity

HACC services seek to support the ongoing independence of elderly and disabled Australians to remain living in the community rather than entering residential care facilities[1, 15]. There are a wide range of services funded by the HACC program. Two services clearly are associated with the provision of food; meal services and other food services[1] (see box below) however, other services may also incorporate elements of food and nutrition services.

Meal services: Provision of meals prepared and delivered to the clients' home or provided in a community centre

Changes in aged care services are underway in Australia under the Commonwealth Government's National Health Reform. The National Health Reform for Aged Care aims to ensure that all levels of aged care, from community-based to residential care, operate under a coherent aged care system[42]. Central to the reforms is the Commonwealth Government's acquisition of the funding and policy responsibilities for aged care services (except for in Western Australia and Victoria) commencing in July 2011, a responsibility previously borne by the states and territories[42]. In August 2011, the Productivity Commission released their report on their investigation into aged care services, *Caring for Older Australians,* which acknowledged significant weaknesses in the Australian Aged Care Services system and made recommendations to the Commonwealth Government for changes to Aged Care Service Policy[43]. In April 2012, the Australian Government responded to the Productivity Commission's report with *Living Longer Living Better*, which outlines which of the Productivity Commission's recommendations will be supported in full, partially or not at all, and committed to significant aged care policy changes for the future[44].

For the community-based aged care service system in Australia, *Living Longer Living Better* heralds significant changes with the aim of moving towards a more integrated aged care system that facilitates greater consumer choice and easier transitions between levels of care[44]. Selected features of the reforms include ongoing support for aged people to remain living independently in the community, a revised means testing protocol with an emphasis on individuals contributing to their personal care costs based on their ability to pay, and the establishment of an Aged Care Gateway to facilitate easier access to, and progression through, the aged care system (including a new website, national call centre and development of a national assessment framework)[44]. Importantly, the Aged Care Reforms have an increased focus on supporting diversity in residential and community settings with the aim of supporting diverse populations such as people from CALD backgrounds to be able to access information and services that are culturally appropriate[44]. *Living Longer Living Better* acknowledges that culturally sensitive diagnostic tools will be vital to ensuring that assessment processes are suitable and standardised[44].

The special needs of the CALD elderly are also acknowledged in the HACC Program Guidelines, with a key performance indicator relating to adequately engaging these groups[15]. Concerns have previously been expressed that HACC services are not adequately engaging CALD elderly[1, 24], and that mainstream (generic) aged care services (who deliver the majority of HACC services) are not able

to meet the diverse needs of CALD elderly[45]. These concerns appear well-founded given that in Queensland in 2008-09 based on country of birth less than 40% of the HACC eligible CALD population actually accessed HACC services[15].

A recent study[28] explored the aged care needs of eight emerging communities in the greater Brisbane area and found that these communities experienced barriers to accessing aged care services similar to those previously reported in the literature[45]. Barriers identified in this study included a general lack of information on aged care services and language hindering access and awareness of services[28]. It was also found that communities varied in their preferences for the way information was received and the way aged care services themselves were delivered. This emphasises the importance of community consultation in the design and delivery of culturally appropriate aged care services.

1.5 Meals on Wheels (MOW)

Meals on Wheels (MOW) is an Australia-wide organisation that provides delivered meals to the frail elderly, disabled young people and their carers, aiming to support ongoing residence in their own homes within the community[46]. MOW services are overseen by a state/territory peak body which, in turn, are overseen by a national body, the Australian Meals on Wheels Association. There are 153 separately incorporated MOW in Queensland which are the major suppliers of HACC delivered meal services[46]. Seventy-seven (50%) of Queensland MOW services operate production kitchens with the remaining purchasing food from health services or commercial suppliers. There are differences in how MOW services are delivered between the states and territories. For example, in some states local governments are largely responsible (e.g. Victoria)[47] whereas elsewhere MOW services are unique, community-based and operated services (e.g. Queensland and New South Wales)[48, 49].

MOW recipients are generally asked to pay for their meals (usually between $5.50-9.00 in Queensland)[49] with a $2.50 HACC subsidy available per delivered meal. There is significant diversity between the different MOW services in Queensland. Whilst the number of MOW services with paid staff in core positions is increasing, the contributions of volunteers are essential to ensure that services remains viable[49]. In addition to differences in human resource profiles, MOW services are heterogeneous in their financial security, client profile, choice of food service model (refer Table 1), size, geographic reach and operating practices[6].

Table 1: Food Service Operational Models

Food Service Model	Description
Cook-Fresh	Meals are cooked fresh on premises and delivered hot/ready to eat
Cook-Fresh-Chill-Reheat	Meals are cooked fresh on premises, chilled for storage and reheated to be delivered hot/ready to eat
Cook-Fresh-Chill	Meals are cooked fresh on premises, chilled for storage and delivered chilled (client reheats)
Cook-Fresh-Freeze	Meals are cooked fresh on premises, frozen and delivered frozen (client defrosts and reheats)
Purchase-cook-chill-reheat	Purchase a meal which has been cooked and then chilled, reheat and deliver the meal hot/ready to eat
Purchase-cook-chill	Purchase a meal which has been cooked and then chilled, deliver the meal chilled (client reheats)
Purchase-cook-freeze-reheat	Purchase a meal which has been cooked and then frozen, defrost and reheat the meal and deliver hot/ready to eat
Purchase-cook-freeze	Purchase a meal which has been cooked and then frozen, deliver the meal frozen (client defrosts and reheats)
Purchase-cook-fresh	Purchase a cooked meal (hot) from supplier and deliver hot/ready to eat

1.6 Aim

This research seeks to explore the current provision of food services to CALD clients and the barriers and enablers to this service provision. The exploration will make a number of recommendations regarding culturally sensitive service provision for community-based aged care.

This research complements a comprehensive literature review already undertaken[6], the forthcoming development of a data collection tool relating to food preferences and cultural profiles to assist community services in cultural food provision. These elements form part of joint project between Diversicare and QUT *'Meeting the Food Needs of Queensland's CALD Aged'*.

2 Methodology

This research was conducted between October 2011 and January 2012 using mixed methodology comprising semi-structured interviews with representatives of ten Queensland-based aged care service organisations and an online survey of Queensland-based HACC Foodservice providers. This research was approved by Queensland University of Technology Human Research Ethics Committee (Approval number 1100001278).

2.1 Interviews

Sixteen semi-structured interviews were conducted with representatives from ten Queensland-based aged care service organisations between October and November 2011 with the intention of gaining insight into the provision of cultural food services to CALD clients. Prospective agencies were identified for inclusion if they worked within the areas of HACC service delivery (including those delivering services to CALD aged), aged care services and health and nutrition services. Prospective agencies were identified initially by Diversicare to represent a range of geographical areas with high and low numbers of potential CALD clients. Services in regional areas were also included. Agencies then identified the most appropriate managerial or frontline staff to interview, an important aspect of obtaining both a strategic and coal-face understanding of the current situation.

A literature review[6] informed the design of the key informant interview questions attached in Appendix 1. A suitable interview time was arranged and the majority of interviews were conducted by a single researcher (AM). Thirteen of the interviews were conducted face-to-face and three were conducted over the telephone. Two interviews were conducted with participants whose level of English-language was such that the assistance of an interpreter was required. The supervisor from these participants' organisation completed this role as the supervisor was proficient in English. Interviews were audio-recorded with the exception of those conducted over the phone and two of the face-to-face interviews. During all interviews, written notes were taken. Where available, audio-recordings were not transcribed verbatim rather, they were used to augment written notes taken during the interviews to ensure that complete themes and concepts were captured accurately. Where responses were felt to convey significant context and meaning relevant to the research, these were transcribed verbatim to facilitate reproduction in this text.

Interviews were analysed for recurring themes and responses were then collated and summarised. Direct quotes have been used, where possible, to exemplify the key themes.

2.2 Online HACC Service Provider Survey

In November 2011 an online survey was sent to 280 Queensland-based HACC service providers who were listed under the Queensland Health's Online listing of HACC Services providing meal services (http://www.health.qld.gov.au/hacc/serviceprov-info/directories.asp). The survey was distributed by email using the Key Survey™ (http://www.keysurvey.com/) online survey platform. The survey was open for six weeks initially, during which time two email reminders were sent to potential participants. Following the Christmas period, it was determined that due to a poor response rate – potentially associated with the time of year that the survey was run – the survey would be reopened for two weeks and additional reminders sent to garner more respondents. The survey reopened mid January 2012 and closed at the end of January 2012. During this time, two further email reminders were sent out and due to an ongoing poor response rate, one project team member phoned HACC Services individually to encourage them to complete the survey. Potential participants were given the option to decline to participate by sending a reply email with the subject heading 'Not interested' after which time they were removed from the email database and received no further reminder emails pertaining to the survey.

3 Findings and Discussion

The following sections present the findings of the key informant interviews and the online survey. Given the qualitative inquiry style of the interviews, the findings are interwoven with a discussion of important themes. Following this, the results of the online HACC Service Providers Survey are presented.

3.1 Stakeholder interviews

3.1.1 Participants

A total of 21 participants working for 15 aged-care organisations/services participated in key stakeholder interviews. All participants were associated with organisations engaged in providing HACC food-related services to clients. Participants worked for/with Meals on Wheels (n=7), Community Health Centre – Queensland Health (n=2), and for a range of ethno-specific and multicultural HACC-funded aged care service organisations (n=12). Participants filled diverse roles within these organisations including positions such as Executive, HACC Coordinator, Dietitian, Project Officer, HACC Nurse Unit Manager, Community Development Worker, Home Care Worker and Service Director. Representatives from two Brisbane MOW Services participated; along with four Queensland MOW employees working across a range of areas. The two frontline MOW Services operate cook-fresh food services (refer to Table 1 for definition) and are located in areas of Brisbane with ethnically diverse populations.

3.1.2 Client cultural diversity

Most participants identified that their organisations did provide services to CALD clients. Participants representing ethno-specific and the multicultural service providers were able to provide a breakdown of their clients' cultural composition whilst service providers and MOW who were servicing the general population did not have this information available. It is important to note that currently there are no requirements for MOW services to collect information on clients' cultural background. One MOW service, located in a suburb with a high concentration of people born in South-East Asia and the Pacific Islands based on ABS 2006 Census (14.1% born in Vietnam, 1.8% born in Samoa, 0.9% born in the Philippines) [20], estimated that around just 4% of their clients were from a CALD background however

this information was not collected formally, but deduced from client surnames and English language abilities. Similarly, the other MOW service was located in an area with a large Asian-born population[20]. This MOW association estimated that about 10% of their clients were from CALD backgrounds where poor English language skills made communication difficult, but not impossible.

3.1.3 Identification of clients and CALD groups whose service needs are not being met currently

Responses from agencies as to whether the needs of CALD groups were or were not being met fell broadly into three categories:

- Needs being met for all clients, but clients, for a variety of reasons, fail to access the service
- Needs not being met for a range of client groups not only those from CALD backgrounds
- Needs not being met for CALD clients in particular.

Of participants who did not identify any particular client or CALD groups whose service needs were not being met, two felt that the multicultural and ethno-specific services that were already in existence in a range of communities were adequately servicing CALD needs. One MOW service participant felt that there were people missing out on MOW services but often these were the people who were refusing the service once it had been offered. MOW service providers did not specifically identify any particular CALD groups within their catchments that were not receiving food services however, they did report that members of these CALD communities seemed to *"take care of their own"* and this likely impacted service uptake.

It was reported that different groups were experiencing different gaps in current service offerings. Furthermore, community groups other than CALD groups, such as elderly men in general, seniors who were not HACC eligible and elderly identifying as Aboriginal and/or Torres Strait Islander were also identified as not having their service needs met appropriately.

> *"Seniors who are not HACC eligible sometimes cannot get the services that they need. Men seem to be forgotten sometimes, they need extra support…." (Interview 7)*

"There are a wide range of people who slip through the cracks, who aren't identified for some reason, or are identified as needing some form of assistance but don't meet anyone's criteria, particularly when there is other family involvement – the family involvement may preclude them from getting a service when they really need a service…" (Interview 12)

Almost half of interviewees indicated that there were CALD clients whose service needs were not currently being met, yet there was no strong consensus across providers that identified either a specific type of CALD client or specific CALD group. One HACC organisation had conducted their own research into CALD communities within the greater Brisbane area who were likely to require aged care services in the future. These communities included:

- Spanish-speaking community (European & Latin American)
- Former Yugoslavian Republic (FYR) (FYR, Bosnian, Croatian, Serbian)
- African communities (many of whom have arrived as refugees in the last 8-10 years)
- South Asian primarily from India
- Vietnamese
- Pacific Islander
- Filipino

Gaps were identified in service provision, particularly in the availability and delivery of culturally appropriate food services. The identified groups did not all appear to be experiencing the same kind of service gaps with participants from one interview indicating that food services in day-centre respite were not meeting cultural food needs, participants from one third of interviews indicating the same problem existed for delivered meal services such as MOW, and one participant noting a similar issue for meals in aged care facilities and another for in-home meal preparation.

Participants representing several multicultural or ethno-specific aged care service organisations reported that their CALD clients often did not continue on with HACC delivered meal services as the food was not culturally appropriate. It was noted in the interviews that MOW services, one type of HACC delivered meals service, do not routinely collect information on why clients may cease to use their services and this presents a significant barrier to understanding what the reasons are for client attrition (e.g. cultural food preferences, delivery times, cost, etc).

Queensland has higher numbers of Pacific Islander (PI) and Maori people compared to the rest of Australia[50] and participants from one organisation identified gaps in both centre-based and community food services for older people from these groups. Of note, Queensland MOW have also recognised that there is a preference amongst CALD people to access a social meals arrangement once per week through a centre-based service and to take home other meals from this setting. However, this service is not currently available under the existing funding agreement (Tape, personal communication, 27 July 2012). For PI and Maori CALD groups, it was reported that it was culturally preferable, for elderly women in particular, to gather socially to prepare and share a meal together at a central location rather than have someone come into the home to prepare meals. Yet, this activity was not available to them due to occupational health and safety regulations preventing the use of the small domestic style kitchen at the Community Centre at which they hold their centre-based day care activities for the desired group cooking activities (e.g. it only allows two people in the kitchen at one time, requires the use of gloves). This issue was seen to be compounded by the lack of culturally appropriate foods on offer at the centre-based day care as kitchen staff are not trained in PI and Maori food preparation and traditional staple foods are not readily available.

> *"I mean what they would love is a kitchen where they could all go to and cook together in the morning and then share a meal, but that is not going to happen in a HACC day respite centre." (Interview 3)*

> *"It is like when a meal is prepared and brought to the table, they [PI and Maori elderly] will take one look at it and see it, and won't touch it. Maybe they'll have a few veggies, but they won't touch the meat... one example was the meat loaf...it did taste better than it looked but it was quite foreign to them and they just refused to eat it, they won't even try it." (Interview 3)*

HACC delivered meal services, including MOW services, in Queensland were not considered to be culturally appropriate by several participants for a range of CALD groups including clients who follow the Islamic faith, Vietnamese, Chinese, Spanish or Italian communities. Some CALD groups located in South Brisbane, such as the Greek community, have access to a culturally appropriate delivered meal service and centre-based day care food service, but those living outside this area are not currently able to enjoy access to similar services. It was identified in one interview that for the Islamic communities, not only is there no culturally appropriate delivered meal service, but service gaps exist in the

community setting with some clients not being able to access culturally appropriate home-based meal and food preparation assistance.

> *"If there was a service like Meals on Wheels catering Muslim meals it would really be much easier" (Interview 6)*

In summary, when asked to identify any specific CALD groups whose aged care service needs were not being met, while there were mixed opinions, almost half perceived that there were some CALD aged whose needs were not receiving appropriate services but no consensus was reached in specifying a particular CALD group. Gaps were identified in the delivery of culturally appropriate aged care food services with different cultural groups being perceived to experience different service gaps.

3.1.4 Barriers and enablers to accessing and delivering HACC food services

This section reports on responses to questions aimed at exploring the perceptions aged care service providers of the barriers and enablers relating to the provision of culturally appropriate HACC food services, as well as asking about the barriers that CALD elderly may experience in accessing such services.

3.1.4.1 Cultural and religious food requirements and preferences

Participants who identified the need for culturally appropriate delivered food services reported that there was poor uptake of existing delivered meal services amongst certain CALD groups where no culturally appropriate service was available. For example, no food services were identified that appropriately meet the food preference needs of older people from Vietnamese, Islamic, Chinese, Spanish, Italian or PI communities. While some CALD elderly did try a delivered meal service such as MOW, participants frequently reported that the food was not to their liking and they consequently ceased using the service.

> *"About 1 week ago I had a client that needed Meals on Wheels, but they didn't like it… they get orange juice, they like rice, but they didn't get rice. Rice is very important." (Interview 10)*

Within cultural food categories, it was also noted that differences in food preferences and preparation techniques exist. For example, people following the Islamic faith require their food to be Halal; however people of the Islamic faith are from diverse cultures and therefore express different preferences for level of spices and style of foods. Furthermore, some cultures, such as the Vietnamese and Chinese communities, were reported to prefer food cooked fresh and were not comfortable with the idea of reheating pre-cooked meals. Such differences must be considered when contemplating the design of food services to meet Halal and other CALD food needs.

> *"We also need to have varieties of meals… to cover different cultural groups [who all require Halal foods]" (Interview 6)*

> *"They prefer that we go there and cook [rather than access MOW]" (Interview 10)*

For Islamic community members in particular, the need for foods to meet religious requirements was seen to translate into the importance of HACC food service recipients having a degree of trust in the food services ability to comply fully with their food requirements. It was anticipated that this trust would need to be built up slowly over time. Interstate, some HACC delivered meal services have attempted to overcome the difficulties of providing a range of meals that meet different requirements by implementing outsourcing of certain meals or joining forces to create a large central production facility. For example, Nepean Food Services in NSW identified a gap in the variety of reasonably priced Halal meals available and in response, set up a non-funded distribution centre to distribute Gourmania™ meals (from WA)[51]. Corporate sponsorship for a cold storage facility along with marketing the availability of the meals to adjoining services has enabled this initiative to be successful. In Victoria, 20 local councils joined forces to establish a production company, Community Chef, to produce meals for delivered meal services (i.e. MOW) [52]. Community Chef centralised production, enabling the 20 local councils to offer clients a wide range of menu items, including certified Halal meals.

It was frequently mentioned that MOW as the main supplier of HACC funded delivered meal services in Queensland, despite claiming that cultural food needs would be met where possible[53], has a reputation for not offering culturally appropriate meals. This in itself was considered a barrier, impacting on service engagement.

"[Clients] know that MOW does not deliver culturally appropriate foods currently therefore do not access it." (Interview 7)

There are however, examples of existing Queensland MOW services and other similar food service operations that are currently meeting the needs of select CALD communities. Caddies Kitchen, part of Jimboomba Community Care Association Inc. is a MOW service that delivers CALD specific meals to those living in a catchment area of Brisbane that runs from Park Ridge in the north, to Woodhill in the south, Greenbank in the west and Logan Village in the East[54]. It was suggested that there is potential for this service to be a distributor of CALD meals to other MOW services (Tape, personal communication, 27 July, 2012). An example of a non-MOW food service providing CALD specific meals is the Finnish Aged Care Group (FinCare) that delivers culturally appropriate meals to Finnish people across Brisbane (Tape, personal communication, 27 July, 2012). In addition, attempts have been made in the past to establish a range of CALD specific food services in certain regions of Queensland, however these have met with operational, financial and administrative barriers that have prevented their ongoing implementation. For example, in Sunnybank, a Vietnamese program was tested and proved successful, however, insufficient government funding was received to sustain the service. The Holland Park MOW attempted to partner with the Jewish community in the local area, to deliver kosher meals that were prepared by the Jewish community, however the cost of meal production was prohibitive and therefore the service was not implemented.

Purchasing ready-made culturally appropriate meals from external suppliers is an option being considered by QMOW as a way to address the current lack of culturally appropriate food offerings at many services (Tape, personal communication, 27 July 2012). Currently, the QMOW Nutrition Advisor is creating a list of meal suppliers that are able to meet MOW's requirements and provide access to culturally appropriate meals. Meals accessed from these suppliers would all be frozen, which in itself poses issues relating to acceptability and distribution. In relation to acceptability, NSW MOW conducted research into how to meet the cultural food needs of CALD clients and found that frozen meals were not acceptable to the majority (Tape, personal communication, 27 July 2012). Therefore, to improve acceptability of these meals, Queensland MOW services would need to consider reheating meals on site and delivering them hot to clients, which may present operational difficulties for some MOW services.

Whilst there are specific examples of NSW-based MOW services that are successfully meeting the cultural food needs of their catchment communities, such as Liverpool, Fairfield, Marrickville and Rockdale MOW services, the difficulty MOW face in meeting cultural food needs is not isolated to Queensland. A recent New Zealand study asked 36 health professionals and 61 older adults about their knowledge and perceptions of MOW[55]. Health professionals indicated that the current MOW menu did not meet cultural needs and a significant barrier for CALD participants related to the lack of choice over the menu[55].

In the current study, the lack of choice in HACC delivered meal services menu offerings was also identified as a key barrier that limited reach of these Queensland HACC food services, both for traditional Australian and CALD communities. It is important to acknowledge that HACC food services face some significant barriers in providing both traditional Australian and CALD-specific menu items and that many services do try to meet a degree of individual food preferences. For example, some of the barriers that MOW, the largest supplier of HACC delivered meals, face include:

- Heavy reliance on a predominantly volunteer workforce who may not have professional training
- The low HACC meal subsidy and at times poor financial stability
- Increasing fresh food costs
- In some cases inadequate infrastructure to prepare a range of meals
- Lack of consistent operating procedures and standards due to organisational structure; logistical issues (e.g. sourcing a wide range of different ingredients, preparing a variety of different meals to meet different cultural preferences)

Queensland MOW (QMOW) acknowledge that work is required to improve the profile of MOW amongst CALD groups in the community and are conscious of the need to improve marketing and promotion of their services to CALD groups.

The length of time spent in Australia was raised by one participant as a factor that impacted on the relative importance for cultural food services as it was anticipated that those who had been in Australia longer were more likely to be accepting of a more 'Australian' style of eating. That is, it as expected

that the longer length of time spent in Australia, the greater the degree of dietary acculturation[1] that was expected to have occurred:

> *"…especially over the next 20 years, as the immigrants from the second world war age, I feel that they would really appreciate their own cultural foods and I know that that is what they really enjoy when they go to their own respite centres. You know the Polish people and the Russian people, because when they go there, there [are] culturally appropriate foods and that is one of the things that they really enjoy. To me it would be a sort of, umm, they would certainly benefit from it, but I do not see it as a core need, as they have been living in Australia for a long time, they are quite used to the foods here so it would really be one of those secondary things."(Interview 8)*

At this point it is worth highlighting that while the length of time spent in a host country does appear to lead some individuals towards greater dietary acculturation[56], it is not possible to generalise this experience across all CALD individuals due to the multidimensional and dynamic processes that influence dietary acculturation[40]. For example, an individual may enjoy eating an 'Australian-style' meal only occasionally, once-a-day, or at every meal. This is demonstrated by several studies showing that migrants frequently choose a food intake that incorporates both elements of their traditional diet and the diet of the host country[56-58]. In addition, there is some anecdotal evidence that suggests that as cognitive function declines, especially with the onset of dementia, that preferences for foods change[59] and may revert to preferences for childhood or 'comfort' foods.

The issue of culturally inappropriate food in residential care was also raised as an issue, and was put forward as one of the reasons for families electing not to use residential services. This lack of culturally appropriate residential aged care is thought to be one factor contributing to strong uptake of Community Aged Care Packages (CACP), Extended Aged Care at Home (EACH) and Extended Aged

[1] Dietary acculturation refers to the dynamic, multi-factorial process of adoption of the new environments' patterns (such as food selection and eating patterns) by the migrant group[(36)]. It can work in both directions in that whilst the migrant group can adopt some of the host country's dietary patterns, they can also contribute some of their own to the food landscape within which they now reside[(36, 37)].

Care at Home – Dementia (EACH-D) by the CALD aged. These packages meet higher level needs amongst the CALD aged while helping them to remain living in their own homes in the community[60] In 2010, usage rates per 1000 persons for CACPs were greater for people born overseas from a non-English speaking country (6.1 per 1000 persons) compared to those born in Australia (5.9 per 1000 persons)[61]. Similarly, for EACH and EACH-D packages, the rate of use for people born overseas in a non-English speaking country was greater than for Australian born users (1.3 per 1000 persons vs. 1.0 per 1000 persons)[61]. For all package types, use per 1000 persons in the oldest age group (75 years and up) was greatest amongst those born in a non-English speaking country, while for the younger age groups this position was reversed[61]. By making use of these packages, CALD elderly gain assistance which helps avoid entering residential care but which has flow on effects to their families taking on more of the caring responsibilities. Participants in this research indicated that a significant factor contributing to the frequent reluctance of CALD elderly to enter residential care related to the lack of culturally appropriate food on offer in these settings.

> *"There is an issue with nursing homes as many Italians do not go into nursing homes secondary to the dislike of the food there. Family is able to deal with the food issue when the elderly person is in their own home but cannot when they are in a nursing home." (Interview 7)*

> *"We have some of our elderly people who go to nursing homes… and this is a big issue… because they have to go to nursing homes … but they really need help with the Halal… [the need] has not been met at all." (Interview 6)*

3.1.4.2 Culture: food, family, social roles and gender

Participants indicated that traditional social roles played by individuals within their families and extended social networks impact access to, preference for, and delivery of aged care services (including support for carers). In Australia, families are the greatest source of care for the elderly, with women providing the majority of this care[62]. Carers from CALD communities have been found to under-utilise carer support services due to barriers such as language and communication difficulties, lack of comprehension of available support options and how to access these, lack of culturally competent support services, lack of desire to use these services, fear relating to privacy issues and stigma attached to help seeking activities[63].

Different cultures have different norms when it comes to the role of family in caring for their elderly family and other elderly community members. In a study by Carers Victoria of carers from six different cultural groups, it was found that beliefs and values impacted directly on carers' perception of their role, the point in time where carers requested professional assistance, and the level of responsibility they were willing to tolerate[63]. Furthermore, across all the ethnic groups included in the study, family and community expectations as to their role were acknowledged whereas the impact of these expectations varied[63]. Many similar issues and concerns were raised in the current study.

The role of family as carer(s) was seen both positively and negatively by participants in light of the impact it has on facilitating or impeding access to, acceptance and delivery of appropriate food services. While families often provided meals for elderly family members, essentially filling the cultural food service gap, this was also perceived to create a burden for some families or carers.

> *"The family is often relied upon traditionally in the Italian culture to provide meals." (Interview 7)*

> *"We know that this [lack of cultural food offerings] is a barrier to people using MOW, there is a very low uptake of MOW by CALD people… they say "why would I get some stranger cooking me food that I don't like… my family will bring me food, my daughter will bring me food"… which is a burden on families." (Interview 3)*

> *"It does burn out families. But they do, they travel miles at the end of the day, often to leave a meal for mum and dad… it is a huge responsibility." (Interview 3)*

Among many CALD communities the social and cultural expectation that family members will care for the elderly is strong. This can lead to elderly people, or even other family members themselves, refusing needed services for fear of 'losing face' within their social network[63]. This barrier was noted in several interviews.

> *"Particularly with CALD clients, families play a big part with what happens to the elderly person at home. They can be the gatekeepers for good or for ill, in enabling the senior person in the home from accessing services." (Interview 8)*

"Clients from other countries seem to be more family oriented. So they say "yes, yes, yes, family do this…" you have a mile of contacts so you think that it is happening but then they have these other little things going on within their culture where you know, the sons just don't do it or something, you know. And it is that misinformation and getting it right… Until something happens we don't find out that they have slipped through the cracks." (Interview 12)

"They may not want to say that they cannot manage. There may be grown children in the house and they don't want to say that their children are not helping, because they lose face. And so they could be living under extraordinarily difficult circumstances and it appears that support is there but it actually isn't. They won't admit it." (Interview 8)

This 'loss of face' extended to misreporting where the recorded assessment did not always accurately represent true household circumstances, for the same reasons outlined above regarding cultural norms regarding the family's role in caring.

"We don't understand the real family involvement but on paper it says family do this and this and this, but in reality it is more [just] a phone call. Those are the people who fall through the cracks."(Interview 12)

The concept that CALD aged have access to an extensive and supportive caring network (family and/or community) has been criticised as being an over-romanticisation[64]. It is more often the truth that the caring responsibility is undertaken alone, without extensive family support[64] as was reported in a study of Greek-Australian women carers[65]. Assuming that people from CALD communities have ready and extensive access to family and community support to service their food needs without properly determining the true extent of the needs is likely to translate into inadequate, incomplete and potentially inequitable aged care service provision. CALD families are subject to the same pressures as non-CALD families that limit the ability to care for an elderly family member. Also, not all CALD elderly will have access to familial support, and this was seen as a risk to nutritional health and wellbeing.

"And if they don't have family you know, where do they go then? Or they may start eating something that is not appropriate, not good for their health, maybe take-away or maybe snacks that aren't going to be nourishing for them." (Interview 3)

Having awareness of the cultural norms, 'hidden issues' and the barriers these pose to accessing appropriate and adequate aged care services was seen as vital to facilitating equitable service delivery. Indeed, participants from services with CALD orientations were proud of their ability to traverse cultural and social norms and customs to be able to ensure efficient and effective delivery of their services in ways that non-CALD aged care services struggled to do.

"We can usually find a way… it is a close community, people do know one another… there will always be someone in the family or what have you, that we have permission to talk to about providing services. So wherever possible we can usually [find a way]." (Interview 8)

"The other thing too is with services – mainstream services – they know very well that if they go in to see someone for whom English is not a first language, that that assessment is going to take twice as long. They need to get an interpreter… doubling the time, the energy, the cost and you know, some services do it better than others. … it can be very easy to not investigate as thoroughly as one might, about the needs of that person, because you have those huge barriers in the way – the lack of time of the health professional, the difficulties of understanding what the needs are of the culture of the family, and just getting a sense of what really is required in that household." (Interview 8)

Gendered cultural roles were noted to pose a major hurdle to the initiation of HACC services at times. It was seen that it was at times difficult for women to relinquish the caring role and admit that they are no longer capable of caring for their families and/or themselves. It was suggested that an inability to fulfill the caring role may be felt as a loss of face and result in the refusal of appropriate services. This issue has been reported elsewhere, especially in relation to the Greek community, where maintaining family cohesion and family privacy is very important and the use of support services or residential care is not popular[63, 65]. Awareness of such cultural values is essential to delivering appropriate aged care services.

"And I said, "You know, that lady, she has the husband and three grown boys but she will be doing the caring, they won't be doing the caring". And it becomes very hard for women of that ilk to relinquish that role. They are not… it is just not acceptable for them to relinquish that role… and if they do begin to falter, then they may not be supported, so you know, it can be a very difficult process." (Interview 8)

Traditional gender roles apply not only to women, but also to men. Whereas it was acknowledged that women often fulfilled the caring and food preparation role, one participant felt that widowed men may find it difficult to engage in a caring role with their children and/or grandchildren and frequently are not skilled in preparing nutritionally appropriate meals. Bennett, Hughes and Smith found that in a group of 46 widowed men and 46 widowed women from the UK, that men felt that women were better able to cope with the demands of widowhood, largely because they were perceived to have superior domestic skills, but in reality in this cohort a lack of cooking skills was an issue for some, but not all, of the men[66]. Also, while men tended to downplay their levels of socialisation, it was revealed that their experiences were similar to the women participants[66]. No mention was made of the ethnicity of the participants in this study and therefore it is possible that the lived experiences of widowed CALD men differ in a variety of ways.

Food preparation and consumption is an important social activity, although different cultures have different social norms relating to this. It was identified that Muslim elderly were more likely to prefer in-home assistance with meal preparation rather than a delivered meal service as it offers increased opportunity for social interaction, increased flexibility with food preferences and facilitates engagement of senses such as smell during the cooking process. Similarly, participants familiar with Chinese clientele noted a preference for in-home meal assistance as it facilitated the provision of fresh-cooked, culturally appropriate meals.

Participants acknowledged that for some cultures, such as the PI, Maori and African communities, the role women have as 'creators of food' that is then shared with an extended family or in a social setting was important to consider when deciding the most appropriate way to deliver food services. Food services that supported women to continue in this role and acknowledge the importance of the social and communal aspects of meal preparation were perceived to be more acceptable. Participants from one organisation felt that the inability to achieve this type of food service within their organisation due

to regulations (as described above) demonstrated that the regulations did not understand or respect the traditional food practices of women in CALD groups.

> *"…it is not just eating the food… it is the role of women, older ageing women in CALD communities… all their lives their role has been around preparing food and feeding family friends, heaps and heaps of people and its now like that is not valued anymore… it's taken away from them." (Interview 3)*

3.1.4.3 Culture and language

Language was viewed as both a potential barrier and enabler to communication, depending on whether the participants spoke the same language as the client or had easy access to interpreter services. Unsurprisingly, participants reported that when the language was different to what was spoken by the service provider, communication was problematic; cultural familiarity lacking, and the collection of accurate information and the subsequent allocation of appropriate HACC services more challenging. Several participants from CALD-oriented services described how, that even if the assessment had already been completed by a mainstream referring organisation, that they always repeated the assessment when taking on a new client. The motive being that significant information was potentially either missed, or recorded incorrectly, when being completed by a person who was not from the same cultural background, hindering allocation of necessary HACC services.

> *"We do have problems when the person is referred to us and the ONI has been done by another agency… we have a conflict of answers, because…, our community members, they don't open up, they don't say the truth. So in some situations we may actually find that they are incontinent and yet on the form, on the ONI from the other agency, there is no mention of incontinence…" (Interview 7)*

Cultural proficiency was observed to be a great benefit to interpreting client information. The challenge of overcoming language and cultural barriers was acknowledged by one participant from a generic aged care service.

"... and it can be very easy not to investigate as thoroughly as one might, about the needs of that person, because you have these huge barriers in the way – the lack of time of the health professional, the difficulties of understanding what the needs are of the culture of the family and just getting a sense of what really is required in that household." (Interview 8)

This statement points to the importance not only of interpreter services, but of cultural understanding and competency amongst aged care service providers. The difference between bilingual/ bicultural workers and interpreters is that bilingual/bicultural workers not only provide language translation services, but are integral to aged care service delivery whereas, an interpreter's role is constrained to interpreting the language as carefully as possible, without involvement in service delivery[67]. The importance of interpreters having an understanding of aged care services was noted as it was seen to help deliver the contextual understanding required to arrange for and deliver services optimally, a notion that has been supported elsewhere[67]. There was the understanding amongst participants that using an interpreter requires a greater investment of time in completing assessments, and indeed, hiring bilingual/bicultural workers has been reported to be more economical than hiring interpreter services as necessary[67]. Despite acknowledging language as a barrier, all participants (excluding MOW representatives) reported that language was not a barrier, due to the use of interpreters or bi- or multi-lingual workers.

For the MOW services engaged in this study, language presented a larger barrier for the initiation and maintenance of service delivery to CALD clients with poor English language skills, as they did not report having ready access to interpreter services. An interpreter service is available for Queensland HACC services (Queensland Interpreting and Translating Service), the cost of which are covered by HACC, however anecdotal evidence suggests that awareness of this service is very poor (Lok, personal communication, 30 January 2012). Indeed, the MOW services reported resorting to using informal interpreter techniques such as relying on friends and family to interpret the needs of CALD clients without English language skills.

[Talking about a new referral] "...he doesn't speak any English and his only next of kin is a brother who he has no contact with… so… I don't know what we are going to do." (Interview 1)

For home care workers, language and culture were also seen as a highly relevant issue. The home care workers who participated in this research worked for an ethno-specific aged care service organisation and were of the same cultural background as the CALD community which the organisation services. Therefore, it is not surprising that these participants reported experiencing no barriers hindering service delivery. That they speak the same language and have an intimate understanding of clients' culture made delivering in-home food services easy for them. They reported being easily able to source culturally appropriate ingredients and being able to cook the food in clients' preferred style. For these workers, cultural knowledge is a great enabler in the delivery of culturally appropriate services. The food services carried out by these homecare workers are important as there is currently no delivered meal service that meets the cultural food preferences of the CALD groups with whom they work.

For some aged care services, not having home-care workers who spoke the same language or had a good understanding of a client's cultural background was an issue. For example, one participant reported that while their organisation was a multi-cultural service, they did not have any workers available with a Sri Lankan background, which was making it challenging to meet the needs of a Sri Lankan client.

3.1.4.4 Geography

Where a person lives may impact on the ability to access culturally appropriate services. The limited reach of one particular culturally appropriate delivered meals service was acknowledged as being a factor that prevented CALD clients from other areas accessing that service. For example:

> *"…we do provide culturally appropriate meals but it is only within a certain area and we can't service people who live on the periphery or further out, we just don't have the resources to do that, so it means that people who do live on the periphery don't have access to that opportunity." (Interview 8)*

In an effort to ameliorate the effect of being geographically isolated from one's cultural peers, one participant working in an ethno-specific program reported that when determining service priorities amongst clients, that those members of the community that were geographically isolated from cultural peers were given some priority.

3.1.4.5 Community engagement & awareness

Participants representing ethno-specific or multicultural services consistently noted that having bi- or multi-lingual staff that are actively engaged in the targeted communities was essential to the uptake of and acceptance of aged care services.

> *"We employ people within the [CALD] community because they are the ones who are able to spread the word…we are very exposed in the community, a lot of our workers are part of the community." (Interview 7)*

The awareness of their service's activities and cultural orientation amongst referrers such as hospital and general practitioners was seen by participants as an enabler that supported CALD clients accessing ethno-specific services.

> *"In this area there are a good number of culturally specific services out there… they tend to pick up the CALD population and I don't know whether that is hospital based, or G.P based, they go 'Someone has a specific ethnic background so we will go to that group rather than go to HACC'." (Interview 12)*

The unique organisational structure of Queensland's major HACC delivered meal service, MOW, where each service is a separately incorporated entity, has led to a situation where there are limited universal protocols applicable to all associations regarding the promotion of the service within their communities, community engagement, or food production. This diversity was demonstrated by the heterogeneous approaches that two MOW services that participated in this research took towards engaging with their local communities. While one MOW service felt that they were doing all they could manage and that it was the responsibility of the community to come to them to seek services, the other reported actively engaging with the community through a variety of mediums to promote their service. The belief by some MOW services that they should not have to promote their services within their catchments was seen as potentially limiting MOW uptake.

3.1.4.6 Funding and the price of delivered meals

It was noted that insufficient funding was a barrier preventing some HACC food services from being able to meet cultural food needs. Funding needs were identified for activities such as building a commercial kitchen, establishing culturally appropriate food services and training staff and volunteers.

One participant identified that their HACC food service was providing all that they could within the requirements of their funding but noted that when the need was there, that they would provide additional services (funded independently of HACC) to meet client needs as required to assist them maintain independence.

Personal finances of clients were cited as being a barrier to accessing services and it was suggested that often clients were reluctant to pay, regardless of their personal assets. The cost of meals was reported to be an issue for some clients, reducing service uptake. In addition, it was felt that the popular conception by many community members that MOW was a free service, was a barrier to service engagement. The recent Commonwealth Government response to the Productivity Commission 2011 inquiry into Australian Aged Care Services, indicates that aged care reforms will introduce comprehensive means testing for aged care services and individual payments will be based on ability to pay[44]. This reform was acknowledged by as being positive in assisting equitable service allocation.

> *"Promotion would be very important within the community but even then there may be some resistance as the elderly do not like to part with their money easily. They may think that for $8 they could easily prepare a meal, something themselves."(Interview 7)*

3.1.4.7 Meals on Wheels (MOW)

Several participants voiced concern regarding the constraints that the current funding and organisational structure is placing on delivering optimal food services. This section considers only MOW services, not other aged care services that are engaged in HACC food services, as MOW services were what participants frequently referred to throughout the interviews. It is acknowledged that other HACC delivered food services may experience similar barriers and challenges in delivering culturally appropriate food services.

Whilst MOW services are generally well resourced, the structure of funding for MOW in Queensland and the ageing workforce are barriers to achieving optimal operations. It was reported that the income received from the sale of the meals and the subsidy ($2.50 per delivered meal)[49] was not adequate to cover increasing running costs and administration expenses. Significant external fundraising efforts are required to provide access to adequate funding – an activity that some services perform better than others. The financing arrangement for Queensland MOW is different to other states. For example, in NSW, MOW services receive the $2.50 meal subsidy and also receive funding to cover administration costs from the State Government, whereas administration costs are unfunded in Queensland. It is noted that funding agreements will be reviewed as part of the National Health Reforms to aged care. It was noted that achieving increased funding would be essential for improving MOW service delivery and in particular, for equipping services to meet cultural food needs. However, it was also suggested that whilst increased funding would improve services' abilities to provide cultural food services; rather a change to MOW organisation and/or operations may also be required in order to improve service provision and increasing accessibility.

The Queensland MOW organisational structure, where services are independently incorporated and managed by committees and are heavily reliant on volunteers for service delivery, was seen by some as a barrier to adapting MOW to meet more diverse cultural food needs and producing a consistently high quality product. As separately incorporated bodies, achieving consistent product quality, product offerings and procedures was perceived to be challenging.

There was a general perception amongst participants that the majority of MOW services in Queensland do not adequately meet cultural food preferences for CALD clients. It was reported that currently, many MOW services in Queensland may be struggling to produce a high quality meal and one alternative, let alone being ready and able to offer a range of high quality CALD menu option(s). While there is a lack of literature in Australia relating to the acceptability, uptake, and perceptions of delivered meals services amongst CALD aged, a recent New Zealand study suggested that MOW services were not meeting cultural food preferences[55]. Participating health professionals were found to perceive that the existing MOW menu did not meet cultural food needs and CALD participants reported that not having any choice over the menu was a barrier to service uptake[55].

Whilst many concerns were raised by participants as to the ability of Queensland MOW services to meet cultural food needs of their catchment communities, the participating MOW services conveyed a different perspective – noting the barriers that existed to attaining culturally appropriate food services and emphasising that they did the best they could in light of their operational constraints. For example, participating MOW services reported a great sense of wanting to offer the best possible meal to clients and aiming to meet their needs within the means of their service's operational constraints. Participants from one MOW service reported that while they did not offer meals that were designed to be specifically targeted to a particular culture per se, that they were able to make use of some ethnic vegetables (e.g. Chinese greens) due to the flexibility afforded by their cook-fresh food service system. Similarly, the other MOW service reported that while they did not have any resources that focused on meeting cultural food preferences of clients, that when necessary, they would look for culturally appropriate recipes on the internet (although the services involved in this study noted that this was only required infrequently). These MOW services were proud of the fact that they continued to utilise a cook-fresh system as it enabled them to deliver a hot, fresh-cooked meal to clients despite facing not-insignificant financial and operational barriers. Whilst these efforts are to be commended, achieving the delivery of culturally appropriate meals across all services whilst retaining the existing operational structure was noted to realistically be likely to require all MOW services to accept commercial suppliers and their frozen meal products.

Whilst the participating MOW services viewed their cook-fresh system as a benefit in being flexible enough to meet special needs, the divergence in the food service operational models in use by MOW (refer Section 1.5) as it makes consistent production of food of a standardised quality difficult was seen as a barrier to achieving consistent food quality across services. In Victoria, where MOW are largely operated by local councils, 20 services have joined together to support a centralised production kitchen allowing greater product consistency, economies of scale and food variety (Community Chef – see above) [52]. A few participants suggested that individual services in Queensland could potentially partner together to improve capabilities to meet cultural food needs by drawing on their relative strengths. In a similar vein, it was suggested that achieving consistent operations would be more readily achieved if nationally consistent management of MOW existed. However, it was also noted that all models of operations – whether individually incorporated or centrally controlled – all have their associated benefits and challenges.

As a service reliant on a large volunteer workforce, MOW is facing issues common to all other services that rely on volunteers, that is, an ageing volunteer workforce[68] (83% of MOW volunteers in Queensland are over the age of 75 years (Tape, personal communication, 27 July 2012)), underrepresentation of CALD people as volunteers[68] and barriers such as the requisite time commitment, time poor volunteer pool and the cost associated with volunteering[69]. It was reported that many MOW services felt unable or unwilling to ask volunteers to do more than they were currently doing – therefore limiting scope to increase volunteers' responsibilities and engagement in certain activities, and limiting implementation of increased or new activities or practices. Changing the expectation of what was expected of volunteers was put forward as being important to facilitate the improvement of MOW services.

Volunteers currently undertake key roles within MOW services – most often meal production and meal delivery, along with business administration tasks. Concern was raised that some (not all) volunteers had not received appropriate training to complete these activities optimally (a concern mainly for cooking, food service management or small business administration). Some felt that a lack of appropriate training was a barrier to improving organisational performance and expanding cultural food offerings. A lack of financial understanding by some MOW services was thought to potentially contribute to some MOW services believing that increasing meal choices was not an affordable option, when in reality; it could not only be possible but also financially beneficial.

Adequate training of volunteers is a requirement under the 2012 HACC Program Manual[70] and Queensland MOW's five Regional Support Officers are responsible for providing training that services require, including training on meeting cultural food needs. While it was indicated that delivering appropriate training activities to volunteers and employees may improve service delivery, it was noted that engaging volunteers in appropriate training activities was, at times, difficult. It was reported that increasingly volunteers are only willing to complete a very specific role within the service (e.g. deliver meals) and are therefore not interested in receiving additional training for other aspects. A related concern was that sometimes, instead of volunteers attending the training sessions and events; that committee members went along instead. This was seen as an issue some committee members do not actually engage in MOW activities such as cooking or meal delivery – activities that were targeted in much of the training available.

Currently Queensland MOW services are operating under considerable constraints (including those relating to financial, human resource, logistical, business administration aspects of operations) and despite this, many are providing a high quality, essential and appreciated service. However, it appears that Queensland MOW services are largely failing to offer access to culturally appropriate meals to existing and potential clients. In order to adapt and improve the ability of HACC delivered meal services to meet cultural food needs change at some level (for example, organisational and operational) appears to be required.

3.1.4.8 Assessment of clients and their food preferences

The National HACC Program Guidelines indicate that all providers of specific HACC services must consider individual service requirements of clients, such as food preferences[71]. There is little published literature on the food preferences and nutritional status of community dwelling elderly in Australia. For client assessment, all participants, with the exception of those representing MOW, reported using the Queensland Government's Ongoing Needs Identification (ONI) to capture client information[72]. The ONI is separated into different parts including the CORE ONI which consists of four pages that must be completed to facilitate service delivery and these pages contribute to the HACC Minimum Data Set (MDS). In addition to the CORE pages there are additional sections that profile information such as a functional capacity, living arrangements, carers, health conditions, psychosocial information, health behaviours and MDS supplementary information. Cultural information collected in the CORE ONI consists of:

- Country of birth
- Communication needs
- Language spoken at home
- Need for an interpreter[72]

Completing the additional profiles of the ONI provides additional information relevant to meeting cultural food needs:

- Need for assistance with transport and grocery shopping (Functional profile)
- Carer information (Carer profile)
- Oral health (Health conditions profile)
- Speech/swallowing difficulties (Health conditions profile)
- Height, weight and Body Mass Index (Health conditions profile)

- Medicines (Health conditions profile)
- Malnutrition screening (Health behaviours profile)[72]

Some organisations that service CALD communities reported collecting additional information or using a 'Cultural ONI' form that was developed by Diversicare (Lok, personal communication, 2012) or an alternate form. The 'Cultural ONI' assessment form from Diversicare contains questions relating to:

- Year arrived in Australia
- Reasons for moving to Australia
- Language capabilities (spoken and literacy)
- Religion
- Specific dietary needs
- Specific cultural needs
- Social isolation

As mentioned above, the aged care reforms introduced by the Commonwealth Government in April 2012 endorse the use of culturally sensitive diagnostic tools in aged care assessments[44] which is likely to imply changes in the aged care assessment process across the board. It is possible that the Commonwealth Government may implement their Australian Seniors Gateway Agency[44] and was suggested that this service may have the potential to undertake additional screening on behalf of local service delivery agents.

The initial assessment of clients was reported to take at least an hour, with some participants reporting that it could take as long as two to three hours. The expertise of the person completing the form, as well as cultural customs, impacted on the time taken to complete the assessment. The benefits of having staff that were experienced in collecting the necessary information was acknowledged as they were better able to ask questions and respond to answers in a culturally appropriate way that guided appropriate service provision. Several service providers emphasised the importance of collecting the information for the assessment face-to-face as it facilitated the capture of important information and cultural context.

Not all organisations providing services to CALD communities use the cultural assessment form. While organisations that operate a day respite centre reported keeping records on client food allergies

and nutritional requirements, across all participating organisations, specific cultural food preferences were not formally assessed and documented in a thorough or consistent way. The two homecare workers who participated in this study did report collecting food preference information but did not use a specific form to collect food preference information; rather they report using conversation as they engage in delivering meal preparation services to their client to discover food preferences. They reported retaining this information in their memories rather than keeping a formal record.

As noted above, a majority of respondents indicated that the use of bilingual workers and interpreters was a significant enabler to collecting necessary information. One respondent emphasised the importance of using workers that were familiar with the client's culture.

> *"…in the same language and culture, it is easier to find out the true situation, so that therefore the services that are really needed can be arranged." (Interview 7)*

Respondents also identified that in order for clients to feel comfortable disclosing their true preferences it was necessary to establish a trusting relationship which took time and was not always reliant on a paper-based tool.

3.1.4.9 Meals on Wheels: client assessment

Several issues were noted relating to the assessment of clients for MOW associations including: the lack of universal use of available assessment forms; limited regulation/policy in place to mandate collection of specific information; language barriers; and issues relating to the use of volunteers to collect potentially sensitive information.

MOW services in Queensland have access to a standardised form for collecting client information. This form collects basic client information including a question relating to whether or not the client has any special dietary requirements or preferences such as cultural requirements. All clients receive a QMOW brochure titled *'Making the most of your Meals on Wheels'* which requests that clients discuss any special dietary requirements with their MOW Coordinator[53]. This publication is currently only available in English. In this research, participating MOW services did **not** report using the MOW client information form and other participants raised concern that currently different MOW services

collect varying elements of client information and that there are no consistent information collection practices. Client information, when collected, is retained by the services for their own records and is not shared with QMOW. The combined result is that minimal data on MOW clients is readily available. Participants noted that currently MOW services frequently ask clients about their food likes and dislikes, but some may focus on what clients cannot eat as opposed to simply what they do not want to eat or would prefer not to eat for a variety of reasons.

MOW are not required to complete the ONI form for new clients but do have to collect several items to contribute to the HACC MDS. Whilst concern was raised as to whether HACC MDS information was actually being collected accurately, QMOW ensures the accuracy of this data prior to it being submitted.

The reluctance of volunteers to collect what was often viewed as highly personal information was a barrier to collecting client information. As noted above, the potential development of the Australian Seniors Gateway Agency[44] may offer potential for information to be collected centrally, thus removing the need for volunteers to collect such information.

Whilst several participants indicated that the limited regulations and policies mandating the collection of MOW client information as a major reason why MOW services do not collect significant client information it was also noted that the low level of funding ($2.50 per meal) was inadequate to cover the costs of administration and therefore mandates such as those relating to collection of client information would be unfeasible.

Language was a barrier that has been discussed above that is relevant to MOW, as participating MOW services did not report accessing available interpreter services, despite the availability of these services. In addition, and as noted above, participants associated with MOW felt that it was likely that volunteers would not feel comfortable to collect private information from clients. This is an issue that would require careful consideration should such data collection be mandated.

3.1.5 Nutrition Risk Screening

Community dwelling aged persons are vulnerable to malnutrition. A recent Australian study screened 1145 HACC eligible clients in Brisbane, Australia, for nutritional risk and identified 15% of participants as being at risk of malnutrition[33]. Subsequent nutrition assessment of those deemed 'at risk' placed the figure between 5 and 11%[33].

Nutrition screening contributes to maintaining the independence and well-being of community dwelling older adults[16] and systematic and structured nutrition screening programs are recommended as a means for detecting malnutrition early so as to prevent a decline in health status[73]. It has been suggested that aged care services, such as home-based domiciliary care, offer potential for screening community dwelling elderly for nutrition risk[74].

Participants from five interviews reported using the nutrition screening tool that is included in the ONI to conduct their assessments. The ONI contains the Malnutrition Screening Tool as part of the *'Health Behaviour Profile'*[72]. Similarly, participants in five interviews reported that informal monitoring of nutritional status was occurring. For example, workers who have client contact frequently conducted informal monitoring of general wellbeing as they are required to provide regular feedback to case managers on clients. For the two home care workers and the two MOW services who participated, they reported engaging in informal strategies such as checking in client's refrigerators for meals left uneaten, visual monitoring for weight loss and asking about general wellbeing. However, it warrants noting that there is no formal collection or monitoring of this data.

Currently, little is known about the nutrition status of MOW clients as in the past this information has not been widely collected. QMOW's Nutrition Advisor has recently been collecting nutritional information for select QMOW clients however this information was not available at the time of writing. Revised nutritional guidelines were also released by QMOW in July, 2012. These guidelines stipulate the minimum nutritional requirements for meals provided by MOW but do not currently take into consideration any cultural variations.

MOW delivery persons have frequent contact with clients and are well placed to provide a monitoring service and indeed the provision of social contact and potentially monitoring of wellbeing is captured

well by the MOW motto *'more than just a meal'*[51]. Again, the issue of not wanting to ask volunteers to do anything in addition to what they were already doing, and the need for additional training in this area, was noted as a barrier to implementing volunteer-driven nutrition screening of MOW clients.

3.1.6 Improving capacity to meet cultural food preferences

- Strategies identified to increase capacity by participants included:
- Increased funding including the separate funding of HACC food service administration costs
- A cultural food assessment tool
- Increased volunteer numbers
- Guidelines on how to engage communities
- More multicultural workers
- Increased understanding of how CALD communities prefer their services to be delivered
- Additional training, especially for volunteers
- Need to change expectations of volunteers to include collecting information and assessments, and meeting cultural food needs

MOW participants noted that having input from CALD communities to facilitate cultural understanding and to support volunteer numbers would be beneficial in assisting them meet cultural food needs in the future.

> *"The CALD people themselves will need to take their share by making some efforts towards developing their own framework for what they think they should receive. And I think that is happening ... some communities are coming up developing their own services, their own strategies ..." (Interview 3)*

Additional volunteers and more funding were identified as being necessary to support MOW services in the longer term. Training of volunteers (and the resources to support training) was also identified as core needs for MOW, for example in the areas of food preparation, food service management and business administration. Additionally, it was identified that creating better linkages between MOW and other HACC service providers would enhance the profile of MOW and increase understanding of services available. For example, linking MOW with HACC service providers, such as Diversicare, was

seen as being likely to be beneficial in assisting MOW associations to adapt their current services to better meet cultural food preferences.

Advocacy for culturally inclusive services was also identified as important but it was also noted that there needed to be a supply of appropriately trained workers from CALD communities to deliver such services. In that light, the training of more bilingual and multicultural community aged care workers from emerging CALD communities was seen as essential to assist with meeting the cultural food needs of these communities into the future. It was noted that currently members of emerging communities are being encouraged to follow a career path in aged care services; however that often the preference of these workers was to work in residential aged care rather than in community aged care. The perceived increased level of support and team environment offered by residential care facilities was one feature that was considered more attractive than working in the community sector.

Cultural understanding was noted in this current research as being necessary to inform service design and delivery as different cultures have different service wants and needs. The importance of such cultural understanding has also recently been evidenced in a Spiritus report[28].

> *"... there were some cultural groups that were more accepting of strangers coming into their homes than others and some little things that they wanted to have happen and some people said "I want someone from my community to come and give help" and some said, "No, I want don't want someone from my community because they would know all about my business and they would know my family is not looking after me." (Interview 3)*

3.1.7 Future Vision

When asked to give their view of how the cultural food needs of CALD groups will be met in the future, there were varied responses. Some felt that things would not change much, whereas others pictured a future where there were culturally specific meal services for different CALD communities. It was thought that an increase in multicultural diversity may be associated with increasing awareness and acceptance of a wide range of cultural foods, hence making meeting cultural food needs easier in the future and reducing the need for culturally appropriate meals from a core need to a lesser need.

"Ideally a MOW would exist – but would it be Italian? Or Spanish? In addition, the Italian community itself is ageing and it may not have the capacity to set up and run a MOW. Have had discussions with Lite'n'Easy as they have said that they can provide Italian meals." (Interview 7)

"I mean ideally we would love to be able to have a PI [Pacific Islander] worker in the kitchen who would assist, you know, it could be a part time person who would just help out one day a week, to assist with the preparation of those meals… that would be great." (Interview 3)

Participants felt that ideally regulations would consider the cultural preferences of CALD groups for how they wanted their food services delivered, and take this into account when designing policies, regulations and services.

A change in the organisation or operational practices of MOW was also seen as necessary, either by increasing the use of service partnerships that capitalise on various services strengths or in accepting that purchasing culturally appropriate frozen meals from a supplier and delivering them in a desired format (e.g. defrosted and reheated) was an acceptable practice. Another suggestion was the need to consider a different management structure that does not involve multiple small committees as it was felt that some committees may pose a barrier to achieving change on a larger scale.

3.2 HACC Service Provider Online Survey

The HACC Service Provider Online Survey questions were informed by the literature review conducted previously as part of this research project[6]. Questions are included in Appendix 2. The survey aimed to ascertain the cultural profiles of service clientele, food service practices, cultural sensitivity of food service practices, perceived barriers and enablers to achieving culturally appropriate food services, client assessment practices, perceived benefits to the service and clientele that would be achieved from offering culturally appropriate food services and strategies that would be of greatest assistance in delivering culturally appropriate food services. The survey was structured in a way that guided participants to only answer questions that were relevant to their service, based on earlier responses.

3.2.1 Organisation demographics

Of 280 potential participants, only 26 completed responses were received (9.3% response rate). This low response rate indicates that the following results should be interpreted cautiously as they are unlikely to be representative of Queensland HACC Services offering meal services.

Almost half of the respondents worked for organisations which were generic (not ethno-specific) but had CALD capabilities (46.2%). A quarter worked for generic (not ethno-specific) organisations (23.1%), 15.4% worked for ethno-specific organisations servicing multiple communities, three respondents (11.5%) were not sure and one selected other (3.8%) however, later responded that they provided Australian-style food making their classification most likely to be 'generic'. Approximately half identified that less than 20% of their client base identified as CALD (46.2%). At the other end of the cultural diversity spectrum, almost 20% identified that between 81 and 100% identified as CALD (n=5).

When asked to identify any CALD groups in their communities that were currently not having their cultural food needs met, almost half (42.3%) were unable to identify any CALD groups in need of cultural food services. However, amongst those who could identify groups whose cultural food needs were not currently being met, Chinese, Vietnamese, Farsi, Indian, Dutch, Jewish and all the cultural groups requiring Halal meals were identified.

Respondents were asked to identify cultural groups that may have emerging needs for culturally appropriate HACC food services in the next ten years. The most common cultural groups identified as emerging and potentially in need of cultural food services included Asian cultural groups, those from an Indian background, people from Africa and the Philippines. Other cultural groups identified included Afghani, Iraqi, Karen people from Myanmar, French, Italian, South Sea Islanders Maori, Dutch and German.

3.2.2 Interpreter/translation services

Half (50.0%) of respondents reported using an interpreter/translation service when communicating with a CALD client who does not speak English, 23.1% did not and 26.9% skipped this question. Of those who indicated that they do use interpreter/translation services:

- 61.5% reported using written documents translated into their preferred language and telephone interpreter services
- 53.8% reported using appropriately skilled bilingual staff and clients' family or carers to translate
- 30.8% used pictorial resources and documents
- 15.4% used a different form of communication

Lack of access to resources was the primary reason provided for services not using interpreter/translation services to communicate with CALD clients who do not speak adequate English (100%). One third (33.3%) did not do so because it was too expensive, too difficult to coordinate and/or they lacked access to appropriately skilled bilingual staff.

3.2.3 Food Services

Almost three quarters (73.1%) of organisations provided food services. Two respondents initially identified that their organisations did not offer a food service but later noted that they did offer in home meal preparation services, bringing the total of participating organisations who did provide some food services to 21 (80.8%). Only one of the two respondents, who initially indicated that they didn't provide food services but then indicated that they did, went on to answer subsequent food service related questions. Therefore, for the majority of responses, the total number of participants included in responses to food service questions is 20 (where there were 21 responses, this is clearly noted). When asked the proportion of their business dedicated to food services, 30.0% (n=6) did not respond and more than half (55.0%) reported that it was a minor part of their organisation's activities, representing 25.0% or less of business activities. Of organisations providing food services (n=21), almost three-quarters (66.6%) provided a delivered meal, just less than half (30.1%) provided meals at a central location (e.g. centre-based day care) and around one third provided assistance with food purchasing (28.6%) and assistance with food preparation (42.9%) (N.B. multiple responses were permitted).

As expected, a majority of respondent organisations provided HACC services other than food services (76.9%). The most common HACC services provided (not including food services) were:

- 85.0% - social support
- 75.0% - centre-based day care
- 70.0% - domestic assistance
- 60.0% - personal care, transport, respite care

Of the organisations providing food services (n=20), most (50.0%,) had less than 100 clients to whom they provided food services, 30.0% had between 100 and 199, 15.0% had 200 or more and one service indicated 'Other'. Participating food services were not evenly distributed across Queensland Health Service Districts (HSD). Almost one third of respondents were from organisations with food services that service the needs of clients in the Darling Downs-West Moreton HSD and around one third were from Metro South HSD (30.0% each). This is likely to reflect greater cultural diversity in these areas. For example, Darling Downs-West Moreton HSD covers areas such as Toowoomba which has a higher than average population of people born in Sudan whereas, the Metro South HSD includes areas such as Logan which has a higher than average overseas born population and Dunwich which has a higher Aboriginal and Torres Strait Islander population[20].

Three quarters (n=15) of organisations who ran a food service, provided a delivered meal service. Of these, two thirds delivered the main component of the meal hot (66.7%), 13.3% delivered it frozen and one chilled. Two organisations indicated that they delivered meals in hot, frozen and chilled formats. Two-thirds reported using a cook-fresh system and delivering sweets cold (each 66.7%, n=10). Sixty percent (n=9) prepared salads fresh and delivered cold. Around one-third reported cooking food fresh on premises and freezing before delivering frozen (40%). Only two services delivered sweets hot or delivered packed mix soup.

Around one third of respondents who responded to the question relating to menu cycles (n=20) utilised a 4 week menu cycle (35%), 30% had a cycle that was longer than 3 weeks, 20% did not have a cycle and 15% had a cycle of between 1 and 3 weeks. Around one-third of organisations reported that a Supervisor or Coordinator was in charge of setting the menu (31.6%), one-quarter (26.3%) had paid catering staff fulfilling this role, and slightly fewer engaged a dietitian in this process (21.1%). Almost half indicated that a person other than the options provided was involved in the menu formation process (47.4%). Of respondents who indicated the frequency with which their menu was changed/reviewed (n=20), 15.0% changed it weekly, 5.0% monthly, 35.0% quarterly, 5.0% twice per year, 10.0% annually and 5% rarely. One-quarter selected 'other' with two responses including as required, two based on client/GP needs and requests and one respondent every 6 weeks (n=1). A majority of organisations with food services reported using standardised recipes to prepare meals (42.3%), one quarter did not (26.3%) and for 15.7% it was not applicable.

The highest qualifications held by food service staff of the organisations that provide food services varied. Just less than one-third (30.0%) reported their highest qualified food service employee to be an experienced cook with on-the-job training equal to or more than five years. For one-fifth (20.0%) this was an experienced cook with relevant TAFE Certificate III or IV qualifications, 15.0% had a qualified chef, and 10.0% had an experienced cook with relevant TAFE Certificate I or III qualifications. The most qualified food service person engaged in the organisation was in a paid position almost all (90.0%, n=18) of the time.

Participants were asked whether or not their organisations employed staff or volunteers who were of a CALD background and whether or not such people were engaged in consultation to assist the organisation in meeting cultural food preferences. The premise is that such staff and volunteers represent a great resource of cultural knowledge and understanding and will most likely have links with their communities and be able to assist organisations in becoming culturally responsive. More than half of the organisations with food service operations (n=20) reported having food preparation staff from a CALD background (55.0%). Of these organisations, over half (54.5%) reported engaging staff/volunteers from CALD backgrounds in providing input or advice on meeting the cultural food preferences of CALD clients. Just under one-fifth did not do this as they reported having no CALD clients to provide for (18.2%) and the same number were not sure whether this occurred or not. When engagement of staff/volunteers did occur, most often it was done informally (66.7%) with just one organisation reporting utilising a formal process (16.7%). Forms of engagement included contributing to culturally appropriate menu design (33.3%), providing information of food sourcing (33.3%) and providing information on special events that impact food preferences (50%).

Eighteen (90.0%) of the 20 organisations which provide food services replied to the question as to whether or not their organisation assessed the cultural food preferences of clients when determining their food service needs. Of these, 94.4% reported that they do assess cultural food preferences; most often by asking a client a question that aims to detail special cultural food requirements (58.8%), asking a structured question regarding the clients' cultural/ethnic background (52.9%), asking a question about preferred meal patterns (41.2%), not using any structured questions but requesting that staff seek cultural food preference information (23.5%) and 17.6% used a pre-determined checklist of foods/meals to determine preferences (percentages add to greater than 100% as multiple selections were possible). While these results are encouraging, in that most participants indicated making some

kind of assessment of client's cultural food preferences, the limited and frequently informal way in which this was achieved warrants further consideration. Cultural food preferences are difficult to determine simply by relying on cultural and ethnic background and preferred meal patterns. Other details such as religious food requirements, social eating patterns, degree of acculturation and preferences for how assistance is received if required are important considerations in delivering a responsive, client-focused food service.

Seventeen food service organisations responded to the question asking how often clients' cultural food preferences were met. Just over one-quarter reported meeting CALD clients cultural food needs at every meal (29.4%), slightly fewer met them every day (23.5%) and 17.6% did not meet them at all. Delving deeper, it is apparent that the services meeting cultural food requirements at every meal are generic aged care service organisations (generic = 3, generic with multicultural capabilities = 2) and therefore for at least two of these organisations, their ability to meet cultural food preferences was based on having mainly non-CALD background clientele. The two ethno-specific food service providers who were engaged in food services provided culturally appropriate foods on special occasions only and three times per week in line with the frequency that they provided their services of centre-based care and in home meal preparation assistance. Of the three organisations not meeting CALD food preferences at all, only one provided a reason being that there was inadequate demand.

Respondents were given the opportunity to write a free text response detailing perceived barriers to meeting cultural food needs (n=20). Many responses were similar to those voiced in the in-depth interviews reported earlier in this report and include:

- Issues with staff and volunteer skills and minimal training in this area (25.0%)
- Issues procuring the necessary ingredients (25.0%)
- Logistical concerns (25.0%), especially in relation to kitchen facilities not being adequate to facilitate production
- Funding and resourcing constraints were also noted as being a barrier to broadening services to include culturally appropriate foods (20.0%).

When asked to consider possible benefits that might exist **for CALD clients** if their cultural food needs were met, respondents (n=20) identified several important benefits including improved client satisfaction with meals and associated increases in meal enjoyment and happiness (50.0%); as well as improved dietary intake and nutritional status (45.0%). These two benefits are highly important, given

the increased risk that aged people have of being malnourished and/or consuming inadequate macro and micronutrients[57, 73, 75-77] and the association that may exist between risk of malnutrition and depression[76]. Respondents also noted that providing culturally appropriate meal services could also demonstrate the organisation's respect for different cultures (25.0%) and improve community cohesion and settlement of CALD clients into the community (10.0%). Other points noted were an increase in service uptake by CALD clients (10.0%) and improved quality of life for clients (10.0%).

Twenty respondents responded to the item that requested that they conceptualise the benefits that may flow to **the aged care service organisation** should cultural food preferences be met. Responses included comments relating to potential for improved client satisfaction (30.0%), improvements in service quality and morale within the service itself and general organisational benefits (20.0%), better engagement with community members by sharing knowledge and skills whilst simultaneously building new skills in current staff (15.0%) and improved rapport with CALD communities and consequently increased service engagement (15.0%). It is foreseeable that should such organisational benefits be attained by improving cultural food offerings, that the increased engagement with the CALD communities that fall in organisations' catchment areas may help ameliorate some of the volunteer recruitment and retention issues that certain HACC delivered meal services experience[78].

Respondents identified several tools which they would find useful to assist them in meeting cultural food preferences (n=20). More than three quarters thought that a short questionnaire to assess cultural food preferences would be helpful (85.0%), as would be a cultural/traditional food checklist (70.0%). Fewer thought that having pictures of traditional foods would be a helpful tool (45.0%).

Twenty respondents identified strategies that they believed would be most useful for improving their organisation's ability to meet the cultural food preferences of CALD clients such as:

- having access to culturally appropriate recipes (70.0%)
- receiving information on how to integrate culturally appropriate foods into the existing menu (70.0%)
- attaining financial support to establish culturally appropriate food services (70.0%)

There is a resource available, World of Food[38], written in 1995, that identifies cultural foods and recipes for a wide range of CALD groups with the aim of assisting service providers meet cultural

foods needs. As we reported previously in an earlier report, there is anecdotal evidence to suggest that this was not used extensively due to the large size of the resource and the depth of information included[6]. The responses observed here reinforce that such a resource is required, but the format may need adjustment to increase usability. Other responses indicated that lists of suppliers of traditional foods (65.0%), increased financial reimbursement for providing culturally appropriate meals (55.0%), information on meeting nutritional requirements using traditional foods (55.0%), lists of translations for cultural food items and customs (45.0%) and having access to cultural food profiles of specific CALD communities (40.0%) would be beneficial. There are some cultural profiles available for a range of different CALD communities (e.g. Papua New Guinea[79] and Samoa[80]), however whilst these are very important sources of information they do not focus exclusively on food and consequently food-related content is not extensive. There appear to be no stand-alone guidelines or resources available for assisting HACC aged care food services plan and deliver cultural food services and engage the CALD community groups that are present in their catchment areas.

Thirty percent of services had staff whose role includes visiting clients to assist with meal preparation/food purchasing and nine participants responded to the question on what strategies that would be most likely to be useful in assisting in such staff to meet cultural food preferences. Two-thirds perceived that culturally appropriate recipes, information on meeting nutritional requirements using traditional foods, a pictorial reference of key traditional and Australian style foods to assist with interpreting clients food wants and needs and a list of translations for cultural food items would be most helpful. Slightly fewer (55.6%) felt that cultural food profiles of specific CALD communities would be helpful tools.

3.2.4 Nutrition Risk Screening

Participants were asked to respond to a series of questions that were designed to capture whether or not they were regularly conducting activities that contribute to, or facilitate, nutrition risk screening of clients. Results and figures for individual questions relating to nutrition risk screening are included in Appendix 3.

All participants responded to the questions relating to nutrition risk screening (n=26). The majority of organisations reported that they do not collect weight information (65.4%) or weight history (53.9%) from the clients. Just over half reported collecting information on clients' appetite status, however

there was variation with how this was achieved. For example 26.9% collect this information formally at regular intervals whilst 19.2% collect it informally only and 7.7% collect it at initial assessment only. Encouragingly, almost all services reported collecting information on clients' recent wellbeing, either at initial assessment (15.4%), formally at regular intervals (57.7%) or informally (19.2%). Fewer services reported collecting information on recent changes in clients' food and fluid intake with 38.5% doing so formally at regular intervals, 19.2% collecting this information informally and 3.8% collecting it at initial assessment only. Performance was similar for services collecting information on whether or not their clients were having difficulty accessing food, with 30.8% not collecting this information but 65.4% collecting it in some format. Most organisations reported collecting information on whether or not clients were having difficulty preparing food (77.0%).

Only 7.7% of participants indicated that their organisation uses a nutrition risk screening tool when engaging with clients. These organisations perceived that using such a tool was helpful in identifying clients in need of additional food service support. Additional questions were asked pertaining to the use of the tool but due to insufficient numbers, these are not presented.

Participants who indicated that they do not use a nutrition risk screening tool (n=23) provided the following reasons:

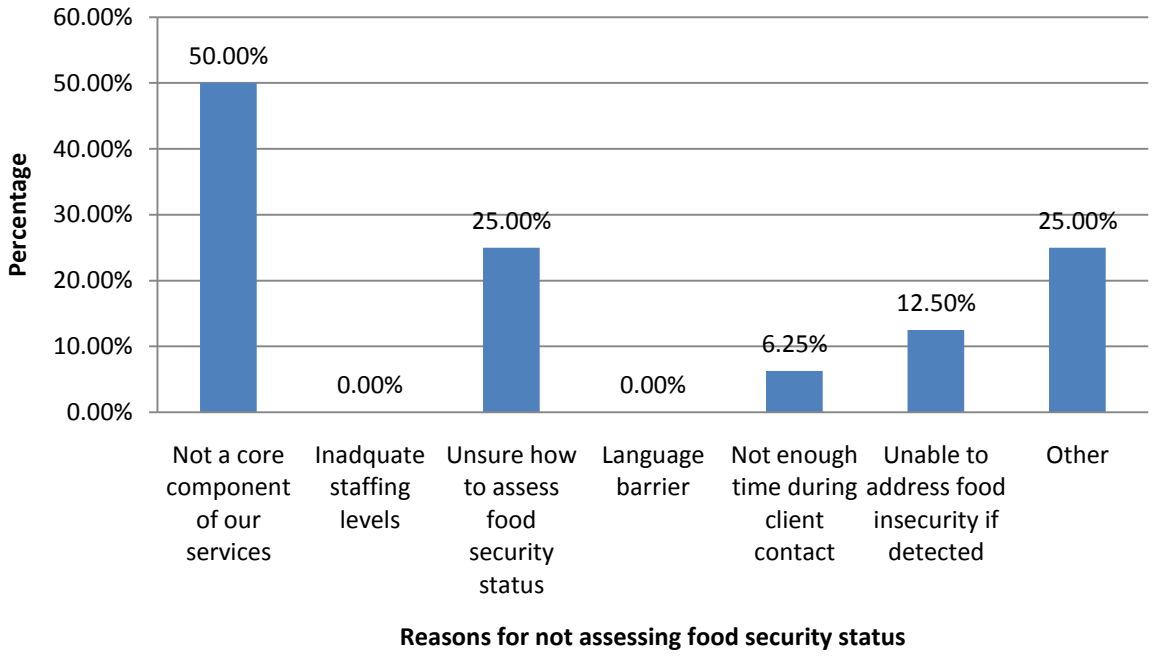
- Do not see it as a core component of their service offerings (34.8%)
- Staff are not trained in administering the tool (30.4%)
- Referring agency/GP does the assessment (13.0%)
- All referrals are made to either a Speech Pathologist or a Dietitian (8.7%)
- Inadequate staffing levels (8.1%)
- Other (15.4%) including responses such as using the ONI tool as required, no funding available for assessment and no tool available to assess nutrition risk

It should be noted that nutrition risk information is usually collected as part of the initial ONI assessment[72], which food service organisations are often not responsible for completing. However, weight, appetite, wellbeing, and food and fluid intake are dynamic, changing for a range of reasons over time. It is therefore recommended that this information is collected periodically[73] amongst community-dwelling elderly who have been identified as a group at high risk of malnourishment.[33]

3.2.5 Food Security

All participants responded to the questions relating to food security assessment (n=26). The majority of respondents indicated that their organisations do not assess the food security status of their clients (61.5%). Of those who do (38.5%) around 40.0% do so by asking a single question regarding whether or not a client has run out of food and been unable to buy more in the last 12 months, 30.0% were unsure of how it was assessed, 20.0% asked a single question regarding whether or not the client has experienced hunger in the last 12 months and one indicated that they do so using the ONI tool (which actually does NOT assess food security status). The reasons for not assessing the food security status of clients are presented in Figure 2. The primary reason was because this is not a core component of the services provided (50.0%).

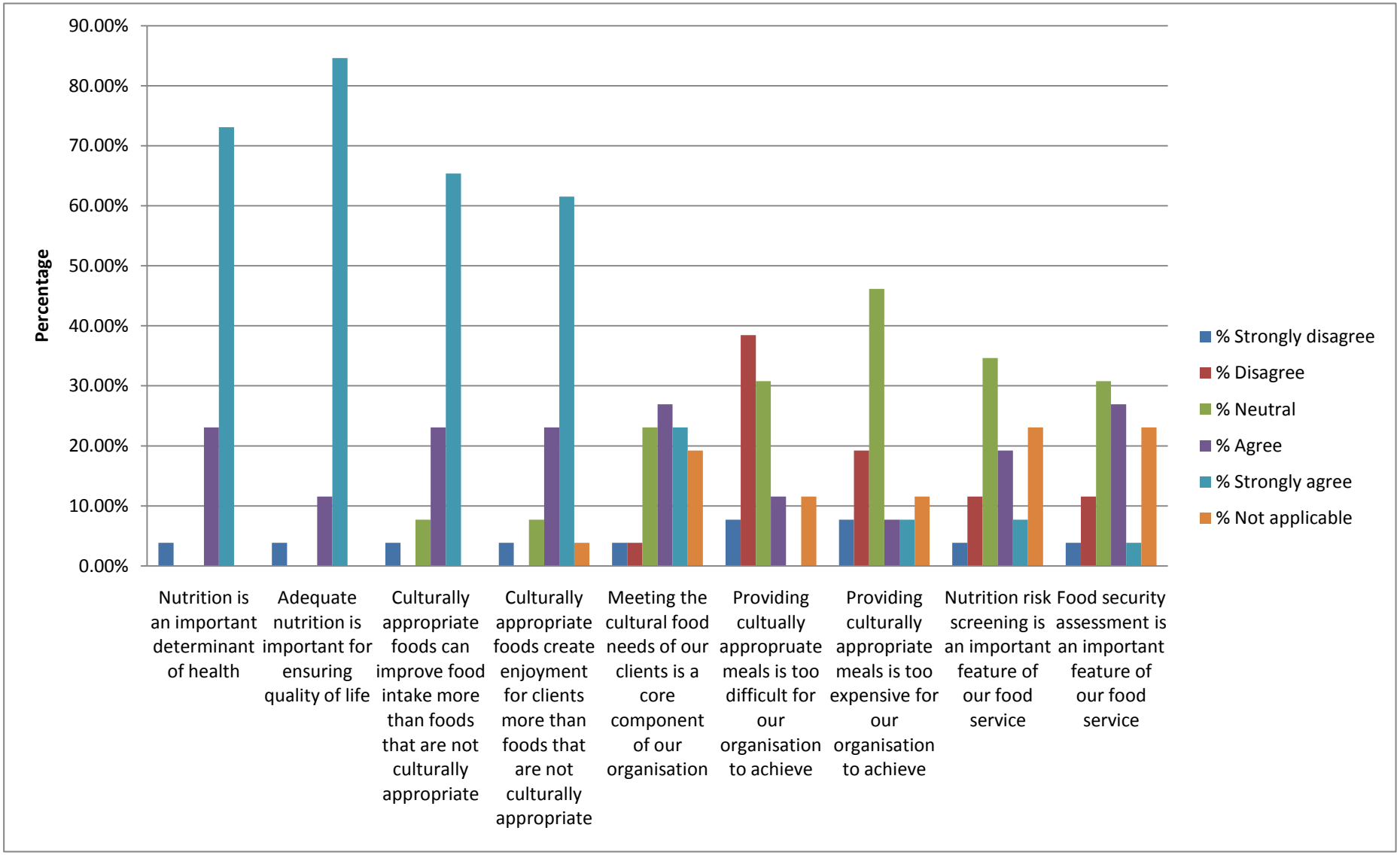
Figure 2: Reasons for not assessing food security status of clients (n=16, multiple responses allowed therefore % add to greater than 100%)



3.2.6 Summary likert measures regarding role of nutrition, culturally appropriate foods and food security

Figure 3 depicts the level of agreeance that service providers (n=26) had with statements pertaining to the role of nutrition in health, the importance of culturally appropriate foods, and the barriers their organisations experience in providing such services. The statements that associated nutrition and health and quality of life, and the important role of culturally appropriate foods in improving client intake and creating enjoyment for clients elicited a strong level of agreement. Positively, almost half of respondents did not believe that providing culturally appropriate meals was too difficult for their organisations to achieve (46.2%), however there was a degree of ambivalence towards whether or not doing so was too expensive with 46.2% being neutral on this point. Similarly there was a degree of ambivalence around whether or not nutrition risk screening (34.6%) or food security assessment (30.8%) are important features or their food services. This reflects the previous findings of only a minority of organisations engaging in formalised nutrition risk screening and food security assessment.

Figure 3: Respondent agreeance with statements of nutrition, cultural food provision, and nutrition risk and food security assessment (n=26)



4 Discussion

Unfortunately evidence drawn from this research appears to indicate that there are specific CALD groups whose aged are not currently able to access culturally appropriate food services. Given the poor response rate observed in the online survey, there is also perhaps a low level of engagement with regard to this issue by HACC service providers across Queensland. It is not known whether this is due to lack of awareness of the existence of need, prioritisation of other needs, or that most services are working with stretched resources that do not allow time for consideration of such issues. For the online survey, most respondents identified that food services was not the only, or even the major, HACC service that they delivered and therefore this may contribute to food service issues not being a high priority for engagement and advocacy.

The findings of this report point clearly indicate the need for culturally appropriate food services to be placed on the policy agenda. Although food services do not attract the greatest share of HACC funding, eating is an essential daily activity that is capable of providing not only nourishment, but also enjoyment, social engagement and improved quality of life both physically and emotionally. Assuming that CALD families have the capacity to continue to provide ongoing food services when required is not appropriate as it burdens families and creates disparities in care provision.

Overall, it appears that several challenges exist for implementing aged care services that meet the cultural food needs of CALD aged. These include:

- A lack of understanding by some HACC services of the cultural food needs and preferences of their catchment areas.
- A lack of demand for HACC food services by some CALD communities. This may be due to cultural reasons where the onus for caring for elders is based with the family as well as a lack of information. Some aged care food service providers would appear to attribute the decision to participate or not in existing HACC food services as resting solely with the CALD individual as opposed to taking a more ecological view and understanding that it is a decision influenced by the availability, or lack thereof, of culturally appropriate food services, in addition to individual preferences and circumstances.
- Heterogeneity of CALD aged and their associated food preferences, service needs and cultural/religious food requirements create logistical difficulties in procuring and

providing a variety of meals each day. It is highly likely that changes will need to be made incrementally to allow systems and organisations to adapt and find solutions that are acceptable to all stakeholders.

- Select CALD groups are having cultural food needs met by various food service formats including day-centre respite, in-home meal preparation and delivered meals which are organised by ethno-specific HACC aged care services or those with multicultural capabilities. However, the most widely available delivered food service, MOW, was not seen to meet cultural food needs for the majority of CALD elderly.
- There are significant gaps in the availability of culturally appropriate delivered meal services in Queensland. For example, there are no delivered meal services in Queensland that provide culturally appropriate meals for people requiring Halal, Vietnamese, Chinese, Italian, Spanish, PI or Maori foods despite large numbers CALD aged in these communities.
- For MOW specifically, a lack of funding (including that obtained through the HACC subsidy), the unique organisational structure, co-existence of diverse production methods, reliance on volunteers (including the fact that volunteers may often lack appropriate skills to meet cultural food preferences), low level of cultural awareness amongst some services and lack of appropriate training were major barriers to meeting the cultural food needs of Queensland's CALD elderly.
- Increased linkages between MOW and other HACC services, particularly with HACC services that are engaged in CALD communities, offers potential for enhancing the ability of MOW to adapt to meet cultural food preferences.
- Little is known about cultural food preferences of Queensland's CALD elderly as this information is not consistently collected in an organised and formal manner. For MOW, several issues impact on the understanding of clients' cultural food preferences including the fact that MOW are not required to collect this information, volunteers are not trained in information collection, volunteers may not feel comfortable or may not be willing to collect this information and for some services at least, there may exist a certain degree of resistance to making the changes necessary to meet cultural food needs.
- The ONI is the main assessment tool used for HACC clients, however this contains minimal information on cultural food preferences and pertinent questions are not mandatory data items as part of the HACC MDS. This assessment is also completed by assessment officers and is not often completed by the participating organisations themselves. This leads to a situation where important cultural information may not be made readily available to the organisations who require it to inform the delivery of client services.
- Some HACC aged care services do collect additional cultural food preference information, but this is not done consistently, in significant detail or using a uniform assessment tool. Therefore, comparison of existing collected data is not currently feasible.
- Nutrition risk screening is most often carried out as part of the ONI at initial assessment. However based on our findings, it appears that MOW and other HACC food services infrequently conduct **formal** nutrition screening. Delivered meals

services and in-home care/meal preparation provides frequent contact between volunteers and clients making them well placed to carry out nutrition risk screening. If this was to occur, volunteers would require training in nutrition risk screening and the change in responsibilities must be managed to ensure that volunteers feel empowered to carry out such tasks.

- Many participating organisations have CALD staff and volunteers. For many participants in the in-depth interviews, the huge contribution such team members make towards assisting engaging CALD communities was readily acknowledged. The online survey revealed that such recognition and engagement of staff/volunteers is not universal. Engaging staff/volunteers from CALD backgrounds represents a great opportunity to building linkages with CALD communities and to share knowledge and skills amongst staff that can improve service delivery and build morale.
- Input from CALD communities will be important in assisting the delivery of culturally appropriate food to CALD elderly – this includes input in the form of guidance on what to cook and how, providing volunteers from CALD communities and promotion within CALD communities.
- Additional funding for infrastructure and day-to-day operational costs was seen as important to helping HACC services meet cultural food needs in the future.
- There would appear to be low usage of interpreter services with just one-quarter making use of such services when working with CALD clients. This poses serious problems in obtaining accurate information, inhibits rapport building and service engagement. It is essential that not only do all aged care service providers have access to interpreter services upon demand, but that they are willing to use them and comfortable doing so.
- A diverse range of food service models are in operation across Queensland HACC food services. This also presents challenges for implementing universal standards with regards to food and nutritional quality and menu variety.
- Many participants saw clear benefits from delivering culturally appropriate food services to clients. These benefits flowed not only to the clients, but to organisations themselves and included benefits such as increased client satisfaction and nutritional status, improved community cohesion and engagement, staff/volunteer skill development and increased morale and importantly, increased enjoyment of meals by clients.

5 Recommendations

Recommendation 1

Meals on Wheels services in Queensland, operating as separate incorporated organisations, provide a valuable service with respect to nutritional intakes and social connectedness in a way that galvanises community action in some areas. However, with increasing legal, reporting, duty-

of-care requirements and the drive to support client diversity under the Aged Care Reforms such a model may be difficult to sustain in the future. Currently, delivered meal services across the country are providing a valuable service by maintaining the health of elderly and disabled, reducing hospitalisations and the use of residential aged care. This is currently undertaken with minimal funding and with heavy reliance on a volunteer workforce that is itself ageing. In order to maximise the benefits and efficiency of delivered meal services it is recommended that:

- **The structure of and operational clarity around delivered meal services in Queensland be reviewed** with the aim of increasing accountability and standardizing food and nutrition quality. A review of the structure does not automatically imply that it will be changed but rather that there will be identification of strengths and weaknesses and identification of opportunities for improvement.
- **A range of avenues be explored** that will facilitate HACC fod services providing culturally appropriate meal services across a boarder geographical area, and to a wider range of ethnicities. It should be noted HACC aged care services must be supported both financially and in terms of resourcing to improve their services and quality whilst maintaining their ability to remain engaged with their communities and be responsive to their community's needs.
- **The funding model for delivered meal services be reviewed** in acknowledgement of rising infrastructure and food costs, as well as potential costs associated with establishing culturally appropriate food services, to reduce reliance on volunteers in managerial roles and to allow services to extend their reach to include provision of meals to CALD aged.
- **The collection of a minimum data set be extended and mandated** for all HACC services to include not only age, gender and number of delivered meals, but also to include nutritional risk status and food security status. This collection of data would need to be accompanied by a concomitant increase in funding. The collection of such data is not only essential in meeting the needs of individual clients but also in the evaluation of food services with respect to nutritional outcomes. This data set should include collection of cultural food preferences to facilitate service planning and ensure diversity is indeed being supported. An inclusive data set encompassing all the required information is being trialled as part of this research. It is recommended that this assessment be altered based on user feedback, to begin to gather the baseline data that is necessary to engage HACC service providers in dialogue on improving cultural equity by incorporating culturally appropriate food services. For the collection of data to mandated additional funding needs to be provided.

Recommendation 2

As the Australian population ages, pressure on the aged care system is forecast to increase, underpinning the government's drive to support aged people to remain living independently in the community for as long as is reasonable. Improving the understanding of all CALD

community's needs and engaging CALD communities in generating solutions for meeting the cultural food needs of their aged is vital to realising sustained independence of CALD aged. The minimal, and inconsistent, information that is currently collected makes it difficult, if not impossible, to plan and evaluate existing food services. In addition, research needs to be undertaken to explore the barriers and enablers, benefits and costs of delivering culturally sensitive food services**. Further systematic research needs to be undertaken to provide this evidence base.**

Recommendation 3

Community consultation and engagement is essential to support the design and delivery of culturally appropriate aged care services to CALD aged. Evidence collected in this research indicates that this is an area where organisations may not be sure of how to proceed. **Clear guidelines on how organisations can engage CALD communities and implement positive, affordable improvements in the cultural offerings of their menus are required.**

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Appendix 1: Questions used in Key Informant Interviews

General

Could you please describe the types of services you offer?

What sorts of clients do you have?

Defining areas of need

Do you think there are any clients that you are currently not meeting the needs of?

Do you think CALD groups use your services? Why/Why not/What do you think stops them?

What about any culturally and linguistically diverse (CALD) groups?

Have you thought of any ways to overcome these barriers?

Are you aware of any need of CALD food services?

Probe for: identification of specific groups?, whether or not their needs are currently being met?, are there groups out there for which there is no information available?, what are the differences in need between different CALD communities?

Assessing food intake/burden of assessment

What sort of information do you currently collect from new clients?

How long does this take? Are there any issues with collecting this data?

Describe how staff currently assess food preferences of CALD clients.

Probe for: who is doing the assessment? What type of assessment is being done? Are cultural food preferences recorded? What amount of time is dedicated to this?

What are the barriers and enablers within your organisation to assess a CALD individual's food preferences?

Probe for: staffing, bilingual staff, time available, actions that may already be occurring.

What do you think you would need to help you identify and meet these needs?

Describe how your staff currently assess the nutrition risk of CALD clients.

Probe for: who is doing the assessment? What type of assessment is being done? What amount of time is dedicated to this?

What are the barriers and enablers within your organisation to assess a CALD individual's food preferences?

Probe for: list of common foods, pictorial resources, how many items to include on assessment, overcoming language barriers

Capacity

What needs to occur to facilitate your organisation in meeting the food service needs of CALD minority groups?

Probe for: resources, extra training, staffing, policy, assistance with recipes or procurement, linkages with other organisations

What would you (service providers) like communities to do to support provision of appropriate food?

Probe for: assistance designing food service products, assistance increasing awareness of culturally appropriate food service offerings

Future vision

Ideally, how do you see the cultural food needs of CALD minority groups being met?

Probe for: idealistic views on future, realities, attitudes

What would you ideally like to see on a cultural food preferences assessment form?

Appendix 2: HACC Service Providers Online Survey

Meeting the Food Needs of Queensland's Culturally and Linguistically Diverse Aged: Survey of Home and Community Care Service Providers

Organisation Information

1. What is the name of the organisation that you work for? (This will be removed and replaced with a code. We need this information to ensure that we do not receive duplicates from the same organisation) Please write your answer in the space below.

   ....

   ....

2. What is the postcode of the suburb in which your organisation is located? Please write your answer in the space below.

   ....

3. Which of these terms best describes your organisation? Please pick one of the answers below or add your own.
   - Ethno-specific (single community)
   - Ethno-specific (multiple communities)
   - Generic (not ethno-specific) but with multicultural/CALD capabilities
   - Generic (not ethno-specific)
   - Not sure
   - Other

Cultural status of organisation's clientele

4. What proportion of your client base is from backgrounds that could be described as being from a CALD background? (This does not include clients who identify as being British, Canadian, American, New Zealand, Anglo-Celtic). Please pick one of the answers below.
   - 0%
   - >0% to 20%
   - 21% to 40%
   - 41% to 60%
   - 61% to 80%
   - 81% to 100%

5. From what background are your CALD clients? (Please select all that apply). Please check all that apply and/or add your own variant.

- Burmese
- German
- Indonesian
- Italian
- Latin American
- Malaysian
- Filipino
- Russian
- Papua New Guinean
- South Sea Islander
- Chinese Greek
- Iranian
- Jewish
- Lebanese
- Maltese
- Polish
- Serbian/Croatian
- Vietnamese
- Dutch
- Indian
- Iraqi
- Korean
- Macedonian
- Portuguese
- Spanish
- Maori
- Sudanese/Burundi/ Rwandan
- Other

6. Please list the top three backgrounds that your CALD clients are from? (based on the percentage they comprise of your total client base). Please write your answer in the space below.

.....

.....

7. When communicating with clients of a CALD background who do not have adequate English language skills, do you use interpreter/translation services? Please pick one of the answers below.
   - Yes
   - No

8. Please select from the list provided all the interpretation/translation services and strategies that you use to communicate with your CALD clients who do not have adequate English language skills. (Please select all that apply). Please check all that apply and/or add your own variant.
   - Written documents translated into their preferred language
   - Telephone interpreter services
   - Appropriately skilled bi-lingual staff
   - Pictorial resources and documents
   - Use clients' carers or family members to translate
   - Other

9. Please select all that apply from the list provided all the reasons why you do not OR are not able to utilise interpretation strategies to communicate with your CALD clients who do not have adequate English language skills. (Please select all that apply)

- Too expensive
- Too time consuming to coordinate
- Lack of appropriately skilled bi-lingual staff
- Lack of access to resources (e.g. pictorial resources/telephone translation/translated documents)
- Other

10. Can you identify any CALD elderly groups that are located in your health service district area whose food service needs are not being met currently? (Please list). Please write your answer in the space below.

    .....

    .....

11. Can you identify any emerging CALD groups in your Health Service District who may need culturally appropriate HACC food services in the next 10 years? (Please list). Please write your answer in the space below.

    .....

    .....

HACC Services and Food Service Characteristics

12. Does your organisation provide food services? Please pick one of the answers below.
    - Yes
    - No

13. What best describes the services around food and nutrition that your organisation provides? (Please select all that apply)
    - Delivered meals
    - Meals provided at a central location (e.g. centre-based day care)
    - Assistance with food purchasing
    - Assistance with food preparation
    - We do not provide services around food and nutrition
    - Other

14. Does your organisation provide other HACC aged care services, other than food services? Please pick one of the answers below.
    - Yes
    - No

15. Please indicate which other HACC services your organisation provides (other than food services)? (Please select all that apply)

- Transport
- Social support
- Respite care
- Personal care
- Nursing care (home)
- Nursing care (centre)
- Home modification
- Home maintenance
- Support and mobility aids
- Self care aids
- Other goods and equipment
- Medical care aids
- Communication aids
- Domestic assistance
- Client care coordination
- Centre-based day care
- Case management
- Carer counselling support
- Assessment
- Allied health care (home)
- Allied health care (centre)
- Other

16. If your organisation offers one or more services other than Food Services, please indicate the percentage of your business that is dedicated to Food Services? Please pick one of the answers below.

- 1 to 25%
- 26% to 50%
- 51% to 75%
- 76% or more
- Organisation does not provide food services

17. On average, how many clients does your organisation provide food services to in a week?

- Less than 50

- 50 to 99
- 100 to 149
- 150 to 199
- 200 to 249
- 250 to 299
- 300 or more
- Organisation does not provide any food services
- Other

18. Which Health Service District does your organisation's food service operation service? Please pick one of the answers below or add your own.
    - Cairns and Hinterland
    - Cape York
    - Central Queensland
    - Central West
    - Darling Downs - West Moreton
    - Gold Coast
    - Mackay
    - Metro North
    - Metro South
    - Mount Isa
    - South West
    - Sunshine Coast
    - Torres Strait and Northern Peninsula
    - Townsville
    - Wide Bay
    - Other

19. Does your organisation provide a delivered meal service? Please pick one of the answers below.
    - Yes
    - No

20. How is the main meal component of the meal delivered? Please pick one of the answers below or add your own.
    - Hot - ready to eat

- Chilled - ready to be reheated
- Frozen - ready to be defrosted/reheated
- Not applicable
- Not sure
- Other

21. If your organisation provides a delivered meal service, what type of food service does it operate? (Please select all that apply)
    - Cook – Fresh (cooked fresh on your premises) and deliver hot
    - Cook – Fresh (cooked fresh on your premises) then chill, plate, reheat and deliver hot
    - Cook – Fresh (cooked fresh on your premises) then chill and deliver chilled
    - Cook – Fresh (cooked fresh on your premises) then freeze and deliver frozen
    - Purchase Cook – Chill (brought to site chilled) then delivered reheated (hot)
    - Purchase Cook – Chill (brought to site chilled) then delivered chilled
    - Purchase Cook – Freeze (brought to the site frozen) then reheated and delivered hot
    - Purchase Cook – Freeze (brought to the site frozen) then delivered frozen
    - Purchased ready to eat from a supplier such as a restaurant
    - Salads – prepared fresh then delivered cold
    - Soup – deliver packet mix
    - Sweets - delivered cold
    - Sweets - delivered hot
    - Not applicable
    - Other

22. If you have a menu cycle, please indicate how long your menu cycle is? Please pick one of the answers below.

- Do not have a menu cycle
- 1 week
- 2 weeks
- 3 weeks
- 4 weeks
- 5 weeks
- 6 weeks
- More than 6 weeks

23. Who is responsible for setting the menus or making decisions about food choices offered? (Please select all that apply)

- Supervisor/Coordinator
- Food Service Coordinator/Manager
- Catering staff - paid
- Catering staff - volunteer
- Dietitian
- Manager/Coordinator of Nursing
- Steering committee
- Community stakeholder group
- Other

24. How often is the menu reviewed or changed? Please pick one of the answers below or add your own.

- Daily
- Weekly
- Fortnightly
- Monthly
- Four times per year
- Twice a year
- Yearly
- Rarely
- Never
- Other

25. What is the highest qualification held by staff directly involved in food preparation? Please pick one of the answers below or add your own.

- Qualified chef (completed apprenticeship)
- Experienced cook with relevant TAFE Certificate III or IV qualifications
- Experienced cook with relevant TAFE Certificate I or II qualifications
- Experienced cook with on-the-job training of equal to or more than 5 years
- Experienced cook with on-the-job training of less than 5 years
- No experienced staff
- Don't know/Not sure
- Other

26. Please indicate the employment status of the most qualified food service staff that you engage? Please pick one of the answers below or add your own.

- Paid
- Volunteer
- Other

27. Does your organisation's food preparation staff use standardised recipes? Please pick one of the answers below and add your comments.

- Yes
- No
- Not applicable
- Don't know / Not Sure
- Comments

28. Does your organisation have food-preparation staff/volunteers that are from one or more CALD backgrounds? Please pick one of the answers below.

- Yes
- No

Cultural Food Preferences

29. Does your organisation engage staff/volunteers from CALD backgrounds in providing input or advice on meeting the cultural food preferences of CALD clients? Please pick one of the answers below.
    - Yes
    - No
    - Not applicable as do not have clients from CALD Backgrounds
    - Don't know/Not sure

30. How does your organisation engage its food preparation staff/volunteers from CALD backgrounds in meeting the cultural food preferences of CALD clients? (Please select all that apply)
    - Formally (for example, through membership on menu review committee)
    - Informally (for example, in general discussions about menu items and delivery)
    - Contribute to culturally appropriate menu design
    - Provide information on food sourcing
    - Provide information on special events that impact food preferences
    - Other

31. Does your organisation assess the cultural food preferences of CALD clients when determining their Food Service needs? Please pick one of the answers below.
    - Yes
    - No

32. If your organisation does assess the cultural food preferences of its CALD clients, what methods are used? (Please select all that apply)
    - Ask client/carer a structured question regarding the client's cultural/ethnic background
    - Ask client/carer a structured question that aims to detail special cultural food requirements (e.g. Halal, Vegetarian)
    - Use a pre-determined checklist of foods/meals to determine preferences
    - Ask client/carer a structured question about preferred meal patterns (e.g. hot breakfast, small/large lunch, small/large dinner)
    - No structured questions/checklists used but staff advised to seek cultural food preference information
    - Other

33. What actions does your organisation currently take to attempt to meet the cultural food preferences of its CALD clients? (Please select all that apply)

- Meals based on a range of different CALD cuisines are incorporated into food service offerings
- Multiple meal and food options are available for selection
- Meals and foods are delivered chilled/frozen/ready for preparation to allow flexibility in determining meal times
- Offers culturally appropriate foods on dates which are known to have cultural significance
- We do not take any actions to meet the cultural food preferences of CALD clients
- Other

34. How often does your organisation meet the food needs of its CALD clients? Please pick one of the answers below and add your comments.

- Not at all
- At every meal
- Every day
- Three times a week
- Weekly
- Monthly
- Special occasions only
- Comment

34. If your organisation is unable to or chooses not to meet the food needs of its CALD clients, please indicate the reason(s) why? (Please select all that apply)

- Cost is prohibitive
- Demand is not adequate
- Logistical issues are prohibitive (e.g. coordinating multiple meal types, delivery requirements)
- Inadequate staffing levels
- Inadequate skill level of staff
- Lack of information of clients' cultural food needs
- Difficulty meeting nutritional requirements when using traditional foods
- Difficulty sourcing appropriate ingredients/food items
- Do not think it is necessary
- Not a priority for our organisation
- Other

36. Does your organisation assess the cultural food preferences of its clients when determining their Food Service needs? Please pick one of the answers below.

- Yes
- No

37. If your organisation does assess the cultural food preferences of its clients, what methods are used? (Please select all that apply)

- Ask client/carer a structured question regarding the client's cultural/ethnic background
- Ask client/carer a structured question that aims to detail special cultural food requirements (e.g. Halal, Vegetarian)
- Use a pre-determined checklist of foods/meals to determine preferences
- Ask client/carer a structured question about preferred meal patterns (e.g. hot breakfast, small/large lunch, small/large dinner)
- No structured questions/checklists used but staff advised to seek cultural food preference information
- Other

38. Does your organisation currently take any actions to attempt to meet the cultural food needs of clients? Please pick one of the answers below.

- Yes
- No

39. If your organisation does take actions currently to meet the cultural food needs of clients, please indicate the actions taken? (Please select all that apply)

- Meals based on a range of different CALD cuisines are incorporated into food service offerings
- Multiple meal and food options are available for selection
- Meals and foods are delivered chilled/frozen/ready for preparation to allow flexibility in determining meal times
- Offer culturally appropriate foods on dates which are known to have cultural significance
- Other

40. If you are unable to or choose not to meet the cultural food needs of your clients, please indicate the reason(s) why? (Please select all that apply)

- Do not think it is necessary
- Not a priority for our organisation
- Cost is prohibitive
- Demand is not adequate
- Logistical issues are prohibitive (e.g. coordinating multiple meal types, delivery requirements)
- Inadequate staffing levels
- Inadequate skill level of staff
- Lack of information of clients' cultural food needs
- Difficulty meeting nutritional requirements when using traditional foods
- Difficulty sourcing appropriate ingredients/food items
- Other

41. What are the barriers/difficulties you perceive in meeting the cultural food needs of CALD clients? Please write your answer in the space below.

.....

.....

42. What benefits for CALD clients do you perceive exist (could exist) by meeting clients' cultural food needs? Please write your answer in the space below.

.....

.....

43. What benefits for your organisation do you perceive exist (could exist) by meeting clients' cultural food needs? Please write your answer in the space below.

.....

.....

44. Please indicate which tools you believe would be useful for improving your organisations' ability to assess the cultural food preferences of CALD clients? (Please select all that apply)

- Cultural/traditional food check-list
- Pictures of traditional foods
- Short questionnaire to assess cultural food preferences
- Other

45. Please indicate which strategies you believe would be most useful for improving your organisations' ability to meet the cultural food preferences of CALD clients? (Please rank your preferences, starting at 'One' for most useful through to 'Eight' for least useful) Please mark the corresponding circle - only one per line.

- Cultural food profiles of specific CALD communities
- Lists of suppliers of traditional foods
- Culturally appropriate recipes
- Information on how to integrate culturally appropriate foods into the existing menu
- Information on meeting nutritional requirements using traditional foods
- List of translations for cultural food items and customs
- Financial support to establish culturally appropriate food services
- Increased financial reimbursement for providing culturally appropriate meals

46. Do you have staff that visit clients to assist with food purchasing and/or meal preparation? Please pick one of the answers below.

- Yes
- No

47. Which strategies would be most useful to assist these staff meet the cultural food preferences of CALD clients? (Please rank your preferences, starting with 'One' for your most preferred strategy through to 'Five' for your least preferred strategy) Please mark the corresponding circle - only one per line.

- Cultural food profiles of specific CALD communities
- Culturally appropriate recipes
- Information on meeting nutritional requirements using traditional foods
- Pictorial reference of key traditional and ‘Australian’ style foods to assist with interpreting clients’ food needs and wants
- List of translations for cultural food items and customs

Nutrition Risk Screening

Nutrition screening involves identifying those people at nutritional risk of malnutrition or who are experiencing malnutrition. It is considered essential to directing nutrition intervention resources appropriately and contributes to maintaining the independence and well-being of community-dwelling older adults.

For the following questions:

- Formal activities include those that are required due to Policies and Procedures that are in place, or are required to be documented on a clients' file.
- Informal activities include those that are not required under any Policy or Procedure but that may occur as a regular practice amongst organisational staff.

48. Does your organisation collect any information on the weight of clients? Please pick one of the answers below or add your own.

- Yes, formally at initial assessment only
- Yes, formally at regular intervals
- Yes, informally only
- No
- Other

49. Does your organisation collect any information on clients' weight history? (e.g. what their weight was 3 months ago or 6 months ago OR if they have had recent unintentional weight loss? Please pick one of the answers below or add your own.

- Yes, formally at initial assessment only
- Yes, formally at regular intervals
- Yes, informally only
- No
- Other

50. Does your organisation collect information on clients' appetite status? Please pick one of the answers below or add your own.

- Yes, formally at initial assessment only
- Yes, formally at regular intervals
- Yes, informally only
- No
- Other

51. Does your organisation collect information on clients' recent wellbeing (e.g. recent acute illness/stress)? Please pick one of the answers below or add your own.

- Yes, formally at initial assessment only
- Yes, formally at regular intervals
- Yes, informally only
- No
- Other

52. Does your organisation collect information on changes in clients' recent food and fluid intake? Please pick one of the answers below or add your own.

- Yes, formally at initial assessment only
- Yes, formally at regular intervals
- Yes, informally only
- No
- Other

53. Does your organisation collect information on whether clients are having difficulty accessing food? Please pick one of the answers below or add your own.

- Yes, formally at initial assessment only
- Yes, formally at regular intervals
- Yes, informally only
- No
- Other

54. Does your organisation collect information on whether clients are having difficulty preparing food? Please pick one of the answers below or add your own.

- Yes, formally at initial assessment only
- Yes, formally at regular intervals
- Yes, informally only
- No
- Other

55. Does your organisation require the use of a nutrition risk screening tool when engaging with clients? Please pick one of the answers below.

- Yes
- No

56. Which nutrition risk screening tool is used? Please write your answer in the space below.

.....

57. Who does the nutrition risk screening? (Please select all that apply)

- Nursing staff
- Food service staff
- Intake officer
- Coordinator
- Other

58. How often is the formal nutrition risk screen carried out? Please pick one of the answers below or add your own.

- Once at initial assessment only
- Weekly
- Fortnightly
- Monthly
- Three monthly
- Sporadically
- Other

59. How long does the formal nutrition risk screen take per client? Please pick one of the answers below.

- Less than 5 minutes
- Between 5 and 10 minutes
- More than 10 minutes
- Don't know/Not sure

60. What do you perceive as the greatest benefit to nutrition risk screening? Please pick one of the answers below or add your own.

- Helps identify clients in need of additional health services
- Helps to identify clients in need of additional food service support
- I do not perceive a benefit
- Other

61. If you do not use a nutrition risk assessment tool when assessing clients, what is the reason? (Please select all that apply)

- Do not see it as a core component of our services
- Inadequate staffing levels
- Staff not trained in delivering the tool
- Other

Food Security

Food security exists "when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life"

62. Does your organisation currently assess the food security status of its clients? Please pick one of the answers below.
    - Yes
    - No

63. How does your organisation assess the food security of its clients? Please pick one of the answers below or add your own
    - United States Department of Agriculture Food Security Assessment Short Form Module
    - Single question regarding whether or not client has run out of food and been unable to buy more in the last 12 months
    - Single question regarding whether or not the client has experienced hunger in the last 12 months
    - Don't know/Not sure
    - Other

64. If you don't assess the food security status of your clients, please indicate the reason(s) why? (Please select all that apply)
    - Do not see it as a core component of our services
    - Inadequate staffing levels
    - Not sure how to assess food security status
    - Language barrier
    - Not enough time available during assessment/client visits
    - No possibility of addressing food insecurity if detected
    - Other

65. Please identify your level of agreeance with the following statements. Please mark the corresponding box - only one per line.

- Nutrition is an important determinant of health

Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Not applicable

- Adequate nutrition is important for ensuring quality of life

Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Not applicable

- Culturally appropriate foods can improve food intake more than foods that are not culturally appropriate

Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Not applicable

- Culturally appropriate foods create enjoyment for clients more than foods that are not culturally appropriate

Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Not applicable

- Meeting the cultural food needs of our clients is a core component of our organisation

Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Not applicable

- Providing culturally appropriate meals is too difficult for our organisation to achieve

Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Not applicable

- Providing culturally appropriate meals is too expensive for our organisation to afford

Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Not applicable

- Nutrition risk screening is an important feature of our food service

Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Not applicable

- Food security assessment is an important feature of our food service

Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Not applicable

66. From a client perspective, please provide any additional comments on the provision of food for culturally diverse clients/residents. Please write your answer in the space below.

.....

.....

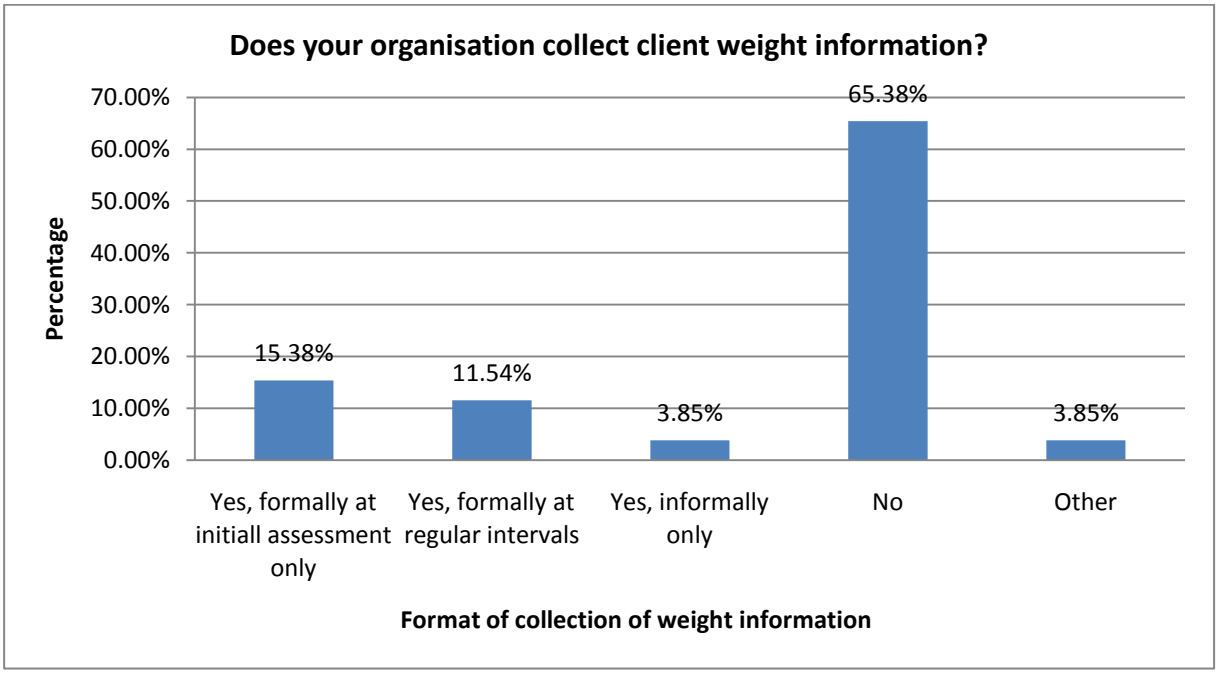
67. From a service provider's perspective, please provide any additional comments on the provision of food for culturally diverse clients/residents. Please write your answer in the space below.

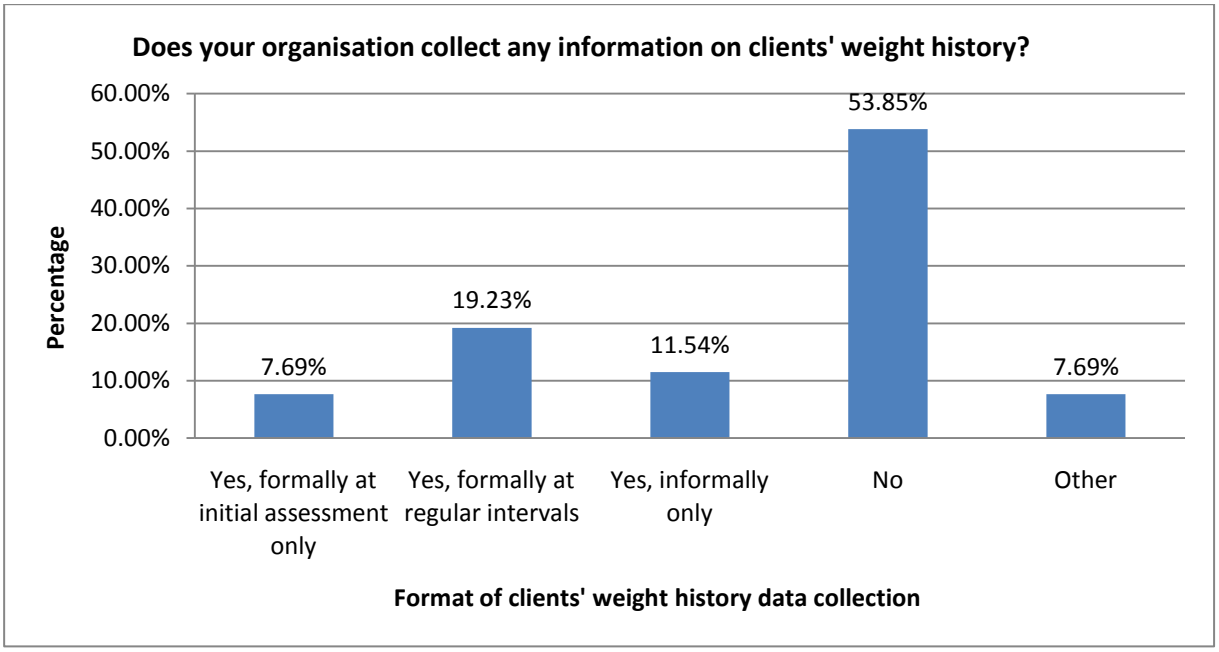
.....

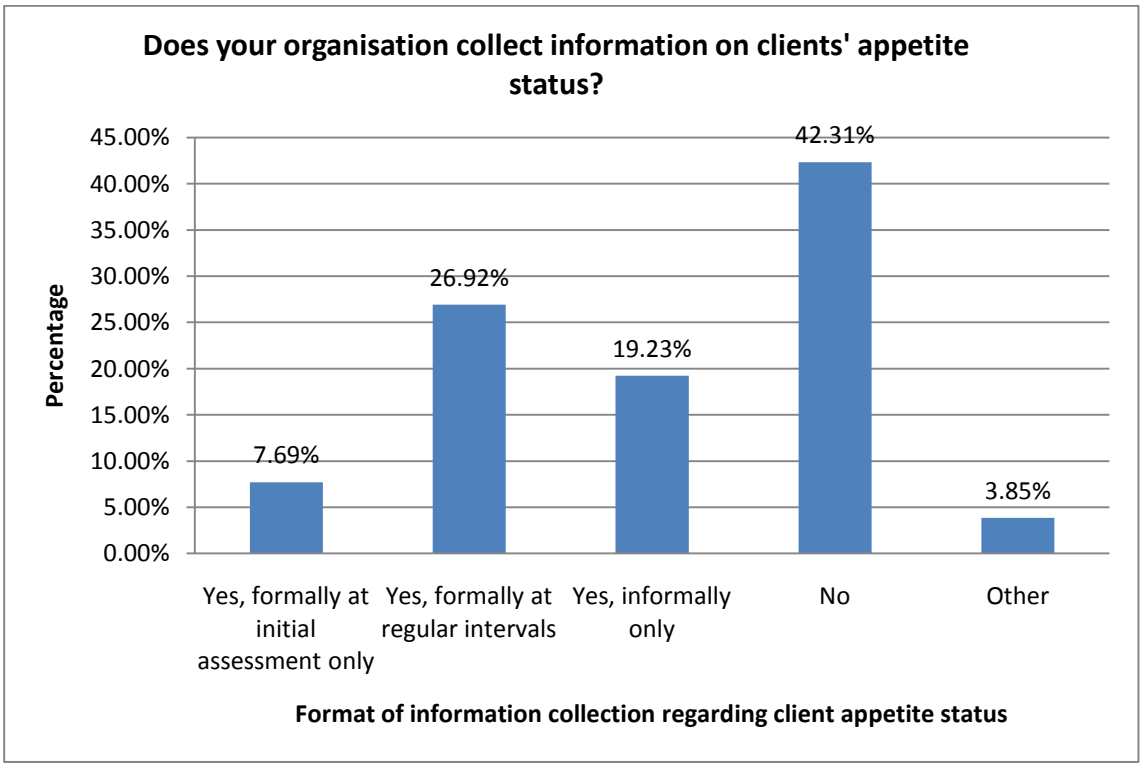
.....

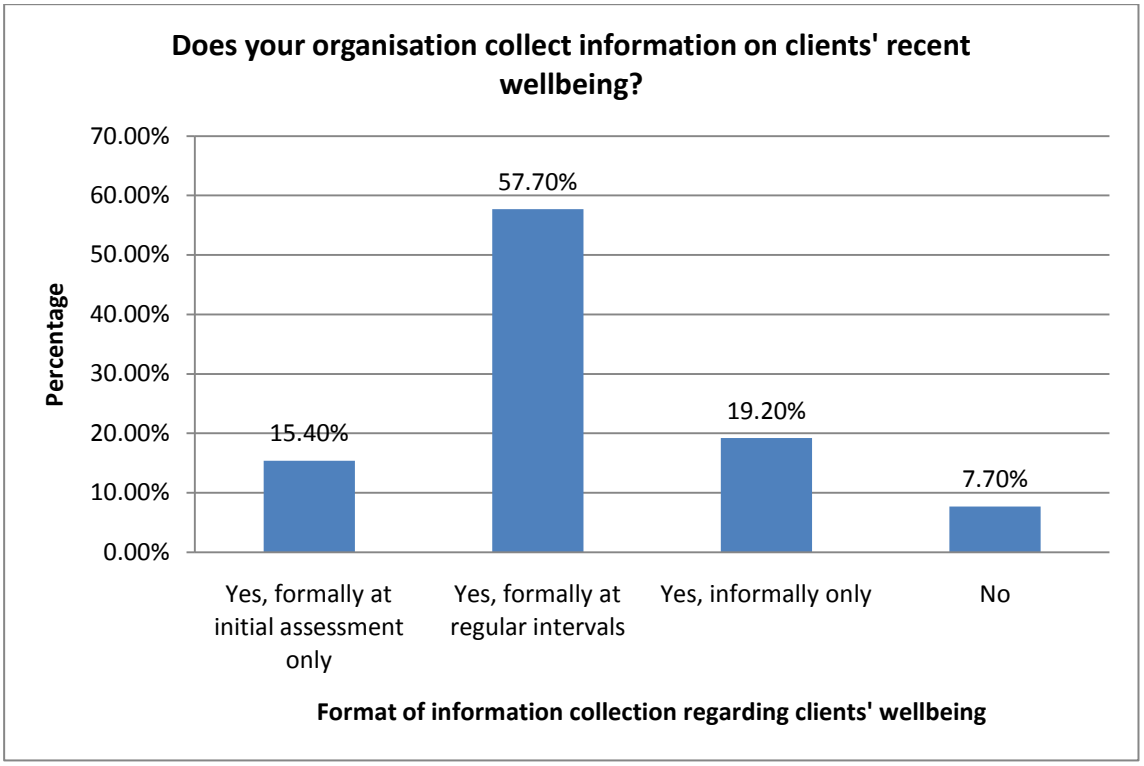
Appendix 3: Nutrition Risk screening – Results and Figures from HACC Service Provider Online Survey

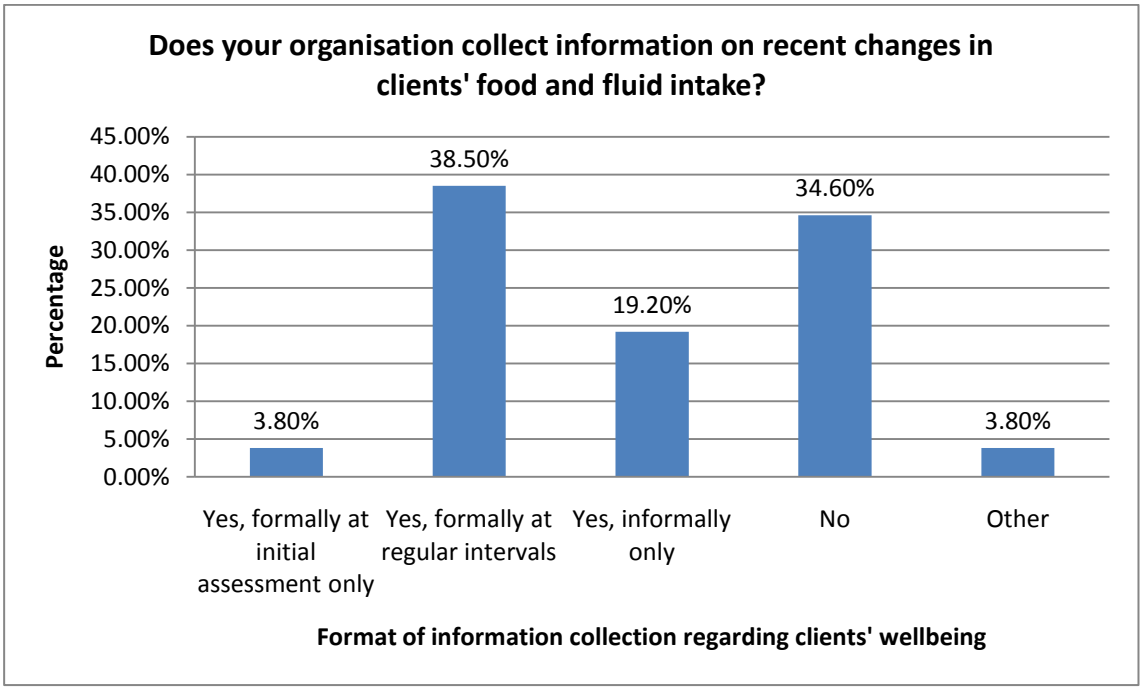
All n=26

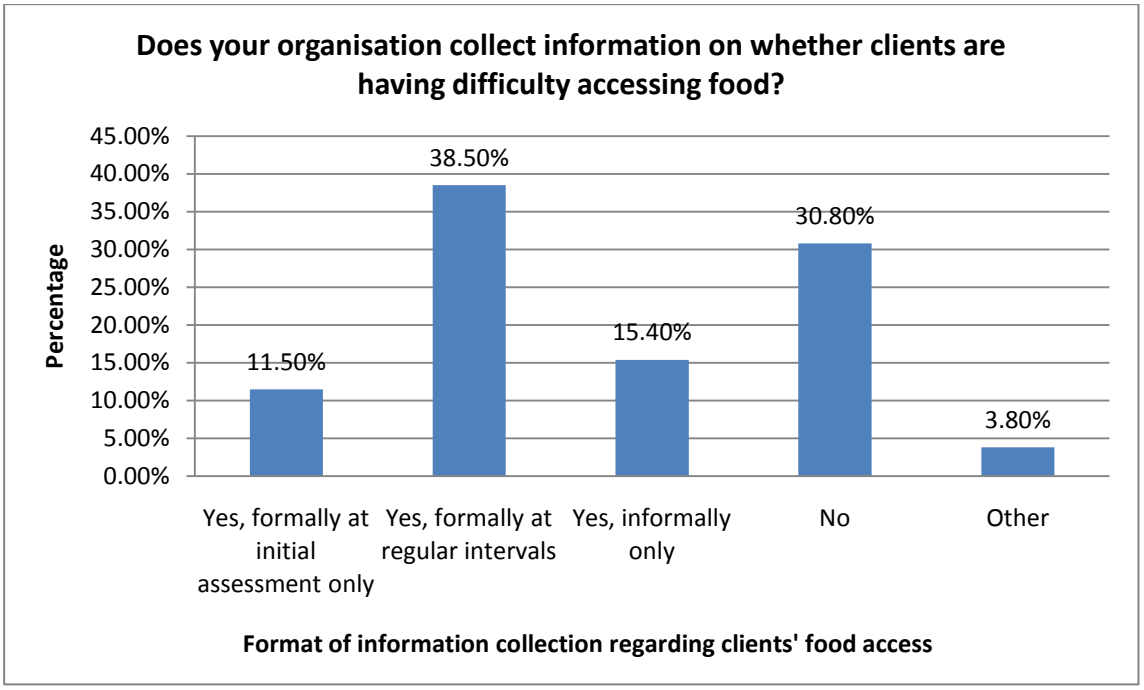


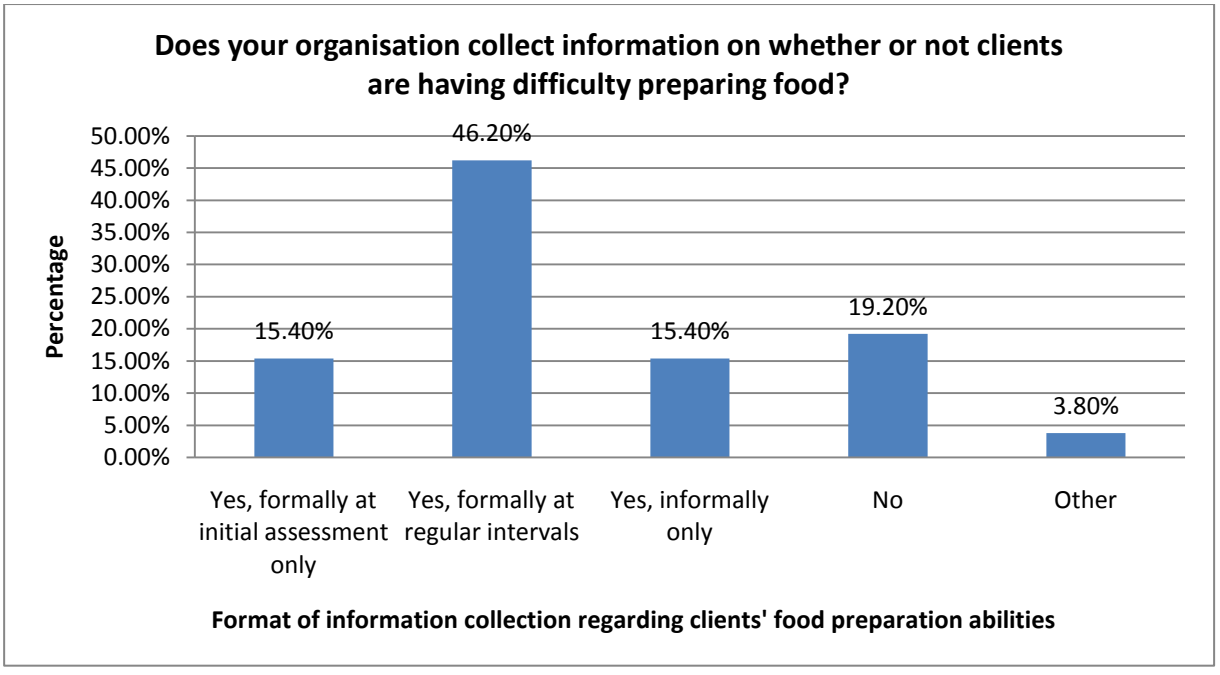

Does your organisation collect any information on clients' weight history?
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Percentage
7.69%
19.23%
11.54%
53.85%
7.69%
Yes, formally at initial assessment only
Yes, formally at regular intervals
Yes, informally only
No
Other
Format of clients' weight history data collection


Does your organisation collect information on clients' appetite status?
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Percentage
7.69%
26.92%
19.23%
42.31%
3.85%
Yes, formally at initial assessment only
Yes, formally at regular intervals
Yes, informally only
No
Other
Format of information collection regarding client appetite status


Does your organisation collect information on clients' recent wellbeing?
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Percentage
15.40%
57.70%
19.20%
7.70%
Yes, formally at initial assessment only
Yes, formally at regular intervals
Yes, informally only
No
Format of information collection regarding clients' wellbeing


Does your organisation collect information on recent changes in clients' food and fluid intake?
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Percentage
3.80%
38.50%
19.20%
34.60%
3.80%
Yes, formally at initial assessment only
Yes, formally at regular intervals
Yes, informally only
No
Other
Format of information collection regarding clients' wellbeing


Does your organisation collect information on whether clients are having difficulty accessing food?
Percentage
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
11.50%
38.50%
15.40%
30.80%
3.80%
Yes, formally at initial assessment only
Yes, formally at regular intervals
Yes, informally only
No
Other
Format of information collection regarding clients' food access


Does your organisation collect information on whether or not clients are having difficulty preparing food?
Percentage
50.00%
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
15.40%
46.20%
15.40%
19.20%
3.80%
Yes, formally at initial assessment only
Yes, formally at regular intervals
Yes, informally only
No
Other
Format of information collection regarding clients' food preparation abilities

Does your organisation require the use of a nutrition risk screening tool when engaging with clients?

Yes = 3/26 (11.54%) (Note: one went on to indicate that they did not use a tool)
Of those, one responded that they used the ONI tool whereas the other used an organisational assessment form and the last indicated they did not use a form??!!

Who does the nutrition risk screening? (n=3)

Intake officer AND/OR coordinator n=2 - 66.67%
Food service staff n=1 - 33.33%

How often is the nutrition risk screening carried out? (n=3)

33.33% (n=1) Once at initial assessment

66.67 (n=2) six monthly

Estimated time spent screening each client? (n=3)

Less than 5 minutes - n=1 (33.33%)
More than 5 minutes - n=1 (33.33%)
Don't know/not sure - n=1 (33.33%)

Greatest perceived benefit of nutrition risk screening:

100% perceived that it helps to identify clients in need of additional food service support (n=3)