Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised.

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The Dietitians Association of Australia (DAA) is the national association of the dietetic profession with over 6000 members, and branches in each state and territory. DAA is a leader in nutrition and advocates for food and nutrition for healthier people and healthier nations. DAA appreciates the opportunity to provide feedback on the 'Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised' by the Senate Standing Committee on Community Affairs.

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DAA interest in this consultation

DAA considers that access to enjoyable nutritious food is essential for the physical and emotional wellbeing of older Australians living in residential aged care facilities. DAA is concerned about the unacceptably high prevalence of malnutrition amongst older Australians and would like to see improved safety and quality frameworks to protect older people.

DAA manages the Accredited Practising Dietitian (APD) program which is the basis for self-regulation of the profession and which provides public assurance of safety and quality. APDs provide medical nutrition therapy to residents identified as at risk of malnutrition, and work with nursing, food service and other care staff to prevent and treat nutrition risks such as risk of malnutrition and dehydration, dysphagia, food allergy and intolerance, food safety, and special dietary requirements in aged care facilities.

Summary or key messages

DAA considers the Aged Care Quality Assessment and accreditation framework does not adequately protect residents from poor practice with respect to food and nutrition, nor ensure proper care standards are maintained and practised.

To ensure that frail older Australians receive adequate food and fluids which are enjoyable and which meet physical and emotional needs, DAA recommends that

- Guidance material accompanying the Single Quality Framework should address food and nutrition systems.
- Accreditors assessing against the Single Quality Framework should receive initial and ongoing training by an APD experienced in aged care food service and nutrition care
- Governance mechanisms in aged care service organisations identify the roles and responsibilities of employees in relation to food services and nutrition care.

Discussion

a. Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised.

Accreditation Standards

The current Accreditation Standards[1] merely state in 2.10 Nutrition and hydration that "Care recipients receive adequate nourishment and hydration." While many service providers deliver excellent nutrition care, this is not the case for all.

Reports from APDs and published studies are evidence that there is an unacceptably high level of malnutrition in older Australia Australians. (see Appendix 1). Undernutrition and dehydration are associated with greater morbidity and mortality, increase the risk of falls, pressure injuries and dysphagia; and negatively impact on cognitive ability[2-8].

The draft Standards, i.e. the Single Quality Framework mentions a single risk, malnutrition, once. It is imperative that the Guidance Material being written to guide service providers and accreditors should address all nutrition risks (including malnutrition and dehydration, dysphagia, special dietary requirements, food allergy and intolerance, and food hygiene) and approaches to reducing the risk of harm to residents.

APDs working in residential aged care report inconsistency in interpretation of the Accreditation Standards. One APD cited superficial attention being given to nutrition issues in one facility, but inappropriate marking down in another facility of a case in which the resident had lost weight, despite a number of interventions being implemented. It is hoped that strategies such as the Computer Assisted Accreditation Tool being developed by the Australian Aged Care Quality Agency will promote consistency. Also, that analysis of data from the Tool will assist in refinement of accreditation procedures and the Single Quality Framework itself.

Training

The experience of APDs suggests that accreditors generally have limited knowledge of food service systems and nutrition care. It would appear that accreditors receive little training from APDs on this important aspect of residential care.

DAA considers that more training of accreditors, both initial and ongoing, is essential.

e. The adequacy of injury prevention monitoring and reporting mechanisms and the need for mandatory reporting and data collection for serious injury and morality incidents

As noted earlier, inadequate nutrition and hydration increases the risk of various injuries to residents. APDs report that most residential aged care facilities weigh patients on a regular basis because this is expected by accreditors. However appropriate action is not always taken on the results. Some service providers have committed to the voluntary contribution of data on unplanned weight loss to the national Clinical Indicator Program. Clearly there is variability in the industry in the approaches taken to monitoring nutrition care.

The Guidance Material which is being developed to support the Single Quality Framework should include the assessment of nutrition risks at entry to care and

various prompts to promote comprehensive food and nutrition systems. Pathways should be identified to act on the results of monitoring. (See Appendix 2 for suggested prompts in quality food and nutrition systems.)

f. The division of responsibility and accountability between residents (and their families), agency and permanent staff, aged care providers, and the state and the federal governments for reporting on and acting on adverse incidents

In the submission from DAA to the Australian Commission on Safety and Quality in Health Care advocating for inclusion of nutrition risk in the revised National Safety and Quality in Healthcare Standards, we noted that food and nutrition matters are "Everybody's business and nobody's business" when it comes to addressing nutrition risk in health services.

The situation is no different in aged care. Provision and consumption of enjoyable food and fluids for residents occurs as a result of the combined efforts of APDs, food service manages, food service staff, care attendants, nurses, and volunteers. At present guidance is lacking for accreditors or service providers regarding the inclusion of responsibility for food and nutrition in role descriptions. Consequently the Guidance Material for the Single Quality Framework should identify responsibilities along the chain of events which support residents to eat well and maintain adequate hydration.

g. Any related matters.

Perhaps it is the everyday nature of eating and drinking which leads to an underestimation of their importance in resident wellbeing. Access to food is a basic human right[9] but it did not rate a mention in the 2007 report[10] of poor care and abuse at the Makk and MacLeay Nursing Home. We know from APDs who were engaged after sanctions were imposed in 2007 that the food service and nutrition care were among the worst situations encountered by very experienced professionals. We do not have reports from those APDs, but understand that they have been provided to the Independent Commissioner Against Corruption.

The 2017 Oakden report[11] hardly mentioned food, and the recommendation of a sessional dietitian in that report will not be sufficient to adequately address food and nutrition care needs of residents.

It seems obvious that more needs to be done to address nutrition and hydration for the wellbeing of residents, and the Aged Care Quality Assessment and accreditation framework is an excellent place to begin.

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Appendices

Appendix 1: Malnutrition prevalence

Appendix 2: Prompts for inclusion in Guidance Material

Appendix 1: Summary of studies of prevalence of malnutrition in Australia

Author	Year of publication	Age of subjects	Number subjects	Malnutrition prevalence	Assessment Tool	Practice setting	State/Territory
Hamirudin et al	2016	>75 yrs	72	1.4% malnourished 27.8% at risk	MNA-SF	General Practice	NSW
Hamirudin et al	2016	Mean: 85±5.8 yrs	79	61.8% at risk or malnourished	MNA	DVA	NSW
Walton et al	2015	Mean: 81.9 (±9.4) yrs	42	5% malnourished 38% at risk	MNA	MoW customers	NSW
Winter et al 2013	2013	>75 yrs Mean: 81.3 ± 4.3 yrs	225	1 malnourished person 16% At Risk	MNA-SF	General Practice	VIC
Ulltang	2013	Mean age 62	153	17% malnourished	SGA	Hospital – MAPU	QLD
Charlton et al	2013		774	34% malnourished 55% at risk	MNA	Older Rehabilitation Inpatients	NSW
Manning et al	2012	Mean: 83.2±8.9 yrs	23	35% malnourished 52% at risk	MNA	Hospital	NSW
Charlton et al	2012	Mean: 80.6±27.7 yrs	2076	51.5% malnourished or at risk	MNA	Older Rehabilitation Inpatients	NSW
Kellett	2013		57	26% moderately malnourished	SGA	RACF	ACT

				7% severely malnourished			
Kellett	2013		101	20% moderately malnourished 2% severely malnourished	SGA	RACF	ACT
Kellett	2012		189	47% moderately malnourished 6% severely malnourished	PG- SGA	hospital	ACT
Gout	2012	59.5 +/- 19.9 yrs	275	16% % moderately malnourished 6.5% severely malnourished	SGA	Hospital	VIC
Ackerie	2012		352	19.5% moderately malnourished – Public 18.5% moderately malnourished - Private 5% severely malnourished – Public 6% severely malnourished - Private	SGA	Hospital – public and private	QLD
Sheard	2012	Mean 70 (35 -92)	97	16% moderately malnourished 0% severely malnourished	PG-SGA		
Agarwal	2010	64 +/- 18 yrs	3122	24% moderately malnourished 6% severely malnourished	SGA	Hospital	QLD
Rist	2009	82 (65–100) yrs	235	8.1% malnourished 34.5% at risk of malnutrition	MNA	Community	VIC metro
Vivanti	2009	Median 74 yrs (65–82)	126	14.3% moderately malnourished 1% severely malnourished	SGA	Hospital – Emergency department	QLD
Gaskill	2008		350	43.1% moderately malnourished 6.4/5 severely malnourished	SGA	RACF	QLD
Adams et al	2008	Mean: 81.9 yrs	100	30% malnourished 61% at risk	MNA	Hospital	
Leggo	2008	76.5 +/- 7.2 yrs	1145	5 – 11% malnourished	PG - SGA	HACC eligible clients	QLD

Brownie et al	2007	65-98 yrs	1263	36% high risk 23% moderate risk	ANSI	Community setting	
Thomas et al	2007	Mean: 79.9 yrs	64	53% moderately malnourished 9.4% severely malnourished	PG_SGA	Hospital	
Walton et al	2007	Mean: 79.2±11.9	30	37% malnourished 40% at risk	MNA	Rehabilitation Hospitals	NSW
Banks	2007	66.5/ 65.0 yrs 78.9 78.7 yrs	774 1434 hospital 381 458 RACF	Hospital 27.8% moderately malnourished, 7.0% severely malnourished (2002), 26.1%% moderately malnourished, 5.3% severely malnourished (2003) RACF 41.6% mod malnourished, 8.4% severely malnourished (2002), 35.0% moderately malnourished, 14.2% severely malnourished (2003) malnourished	SGA	Hospital RACF	QLD – metro, regional and remote
Collins et al	2005	Mean: 80.1 ±8.1	50	34% moderately malnourished 8% severely malnourished (at baseline)	SGA	Community	NSW
Lazarus et al	2005	Mean: 66.8 yrs	324	42.3% malnourished	SGA	Acute Hospital	NSW
Martineau et al	2005	Mean: 72 yrs	73	16.4% moderately malnourished 2.7% severely malnourished	PG-SGA	Acute Stroke Unit	
Neumann et al	2005	Mean: 81 yrs	133	6% malnourished 47% at risk	MNA	Rehabilitation Hospital	

Visvanathan et al	2004	Mean: 76.5-79.8 yrs	65	35.4-43.1%	MNA	Rehabilitation Hospital	SA
Visvanathan	2003	67 – 99 yrs	250 baseline	Baseline 38.4% not well nourished 4.8% malnourished	MNA	Domiciliary care clients	SA metro
Patterson et al	2002	70-75 yrs	12,939	30% high risk 23% moderate risk	ANSI	Community setting	
Middleton et al	2001	Median: 66 yrs	819	36% malnourished	SGA	Acute Hospital	NSW
Beck et al	2001	Mean not available	5749	7-14% malnourished in acute setting 49% malnourished in rehabilitation setting	MNA	Acute and Rehabilitation Hospitals	NSW
Burge & Gazibarich	1999	>65 yrs Mean: 75.2 ±5.8 yrs	92	-High risk: 27% (score of 6 or more) -Moderate risk: 30% (score of 4-5) -Low risk: 43% (score of 0-3) -Most common nutrition risk factors: polypharmacy (47%), eating alone most of the time (45%) and dietary modification due to illness (35%).	Australian Nutrition Screening Initiative (ANSI)	Community living (Senior citizen's centres)	NSW Regional
Cobiac & Syrette	1996	>70 yrs	1098	30% high risk 20.6% moderate risk	ANSI	Community setting	

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Appendix 2: Prompts for inclusion in Guidance Material for the Single Quality Framework

Comprehensive food and nutrition systems should address nutrition risk, where nutrition risk addresses the following

- risk of malnutrition and dehydration
- dysphagia
- special dietary requirements
- food allergy and intolerance
- food hygiene.

Prompts for service providers and accreditors

1. Has an APD experienced in aged care assessed the menu and nutrition care processes? Are recommendations based on the menu, observations made in the kitchen at meal preparation and plating times, observations in the dining room at meal times and in other areas at midmeals by the APD in person? If the service is in a remote location how were these observations undertaken?
2. Is there a multidisciplinary team which considers planning and implementation of nutrition and hydration systems, with participation by APD, consumers/caregivers, food service staff, nursing staff, other carers, other relevant stakeholders?
3. is nutrition and hydration related content included in staff training?
4. Is nutrition included in the resident/consumer care plan?
5. Is responsibility for food and nutrition related issues identified in role descriptions for employees? And for volunteers where appropriate?
6. Are nutrition and hydration policies and procedures in place for each part of the food and nutrition system i.e. in kitchen, in dining room etc?
   Is there communication and cooperation between care staff and food service staff?
7. Is there a program for nutrition risk screening and assessment, at entry and while in care?
   Is there a clear pathway of action when a resident is identified at risk?
8. How do you know the food and fluid choices are appealing and that residents enjoy the food they receive?
9. How do you know you are meeting the needs of people from different cultural and religious backgrounds?
10. What choice is there in the food offered in terms of food items, flexibility of meal timing and service arrangements?
11. Is there evidence that assistance is offered to people who need it? Are people given enough time to eat their meal? Are meals offered at an appropriate temperature?
12. Is the environment of the dining situation pleasant? Are noise levels appropriate?
13. How do you facilitate the involvement of family and friends in meal times?
14. Is there a program of auditing aspects of food and nutrition (including food service, clinical care)?
15. How does your complaints and incidents procedure deal with food and nutrition care complaints?