Food, Nutrition & the Dining Experience in Aged Care

January 2021

Dietitians Australia is the national association of the dietetic profession with over 7500 members, and branches in each state and territory. Dietitians Australia is the leading voice in nutrition and dietetics and advocates for food and nutrition for healthier people and healthier communities. Dietitians Australia appreciates the opportunity to provide feedback to the Department of Health regarding food, nutrition and the dining experience in aged care.

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Dietitians Australia interest in this consultation

As the leading organisation of nutrition and dietetic professionals in Australia, Dietitians Australia (DA) supports reforms to aged care systems and services to better support older Australians who have reduced capacity to care for themselves. In particular, Dietitians Australia considers it vital that the aged care system is changed to improve the standard of food, nutrition and dining experience for elderly consumers in residential and community aged care.

The **Accredited Practising Dietitian (APD)** program provides an assurance of safety and quality and is the foundation of self-regulation of the dietetic profession in Australia. Accredited Practising Dietitians have an important role to play in aged care, such as in the assessment and dietary management of clients with chronic diseases and malnutrition, in the planning and coordination of food service within aged care homes and home delivered meal programs, and in the training of aged care sector staff.

This submission was prepared by Dietitians Australia, informed by **8 aged care Position Statements** prepared by the organisation and available on the website for public viewing here.

Here follows feedback on the options and questions put forward by the Department, which relate to issues within each topic area to be discussed at the *National Congress on food, nutrition and the dining experience in aged care* (Congress) in February 2021.

A. Role of food and nutrition

No.	Issue to be addressed	Option/Question	Dietitians Australia feedback
A1	Managers of some facilities may be unaware of the centrality of good nutrition	Provide education materials linking good nutrition and oral health with reduced overall costs, less over-worked staff and better quality indicator results	Dietitians Australia supports this suggestion. Tailored education materials that demonstrate the cost savings, improved quality indicator results and improvements to workloads with better nutrition are vital. Dietitians Australia has evidence to support this and the skills/expertise to prepare tailored education materials for the aged care sector. Equally, Dietitians Australia recognises that more than education materials/knowledge of facility managers are needed for practice change. Multi-pronged strategies and application of implementation science principles are needed to ensure that real change in nutrition care occurs.
A2	The Aged Care Quality Standards and related guidance may be interpreted subjectively	Review the relevant Quality Standards and related guidance, to minimise subjective interpretation in the residential aged care setting	Dietitians Australia has developed an '*Aged Care Quality Standards Toolkit for Accredited Practising Dietitians (APDs)*', providing APDs with practical strategies to best support aged care organisations to be compliant with the 8 ACQS and furthermore excel in the food, nutrition and mealtime experience space. Dietitians Australia could assist by developing a similar toolkit for providers and their staff.

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A3	Malnutrition is a clinical problem, but involves a huge array of roles and expertise to solve, including personal care workers, nurses, eating aides, kitchen hands, cooks, chefs, dietitians, speech pathologists, occupational therapists, oral hygienists, dentists and others.	How can we increase the interdisciplinary interaction necessary to reduce malnutrition?	Embed mandatory malnutrition screening (1) at the assessment stage; (2) at the beginning of care; and (3) on a regular basis (quarterly re-screening). We recommend that all aged care staff receive annual mandatory training (e.g. via an e-learning module) on how to identify and manage those at nutritional risk using a standardised process with a validated malnutrition screening tool. Residents identified as being at risk of malnutrition, or malnourished, by the screening process are to be referred to an APD for nutrition intervention. Results of quarterly re-screens of nutritional status must replace mandatory reporting on 'unintentional weight loss' in the National Aged Care Mandatory Quality Indictor Program. **Refer to Dietitians Australia's Position Statement on Malnutrition in Aged Care.**
A4	It has been suggested that an extra $10/day/resident be provided by the Government to providers of residential aged care to improve food and nutrition.	If such money were to be provided, should it be directly linked to money spent on food, or would it be useful to allow it to be spent on eating aides as well?	Food only – extra funding should be provided for eating aides and for the mealtime assistance that many aged care residents need.
A5	Lack of training in food, nutrition and the dining experience in the residential aged care workforce	Could the completion of training modules on food, nutrition and the dining experience in aged care by the majority of staff be an accreditation requirement for aged care residential providers?	Dietitians Australia support this suggestion. It is vital that any Nutrition 101 training developed is evidence-based and tailored to the intended market. The linking of mandatory training to accreditation is the only way to ensure that staff fulfil these requirements. **Refer to Dietitian Australia's Position Statements on:** **'Importance of Food in Aged Care' and 'Aged Care Staff Skills and Training'**

A6	There is no documented strategy for addressing malnutrition in aged care	Develop a strategy to reduce malnutrition in aged care	Refer to response provided in A3. In addition to this, it is vital for the Australian Government to develop and implement a 'National Policy for Nutrition Care' in community and residential aged care and provide adequate funding for APDs to implement and monitor the nutrition care policy in all aged care settings. The 'Nutrition Care Policy' would include governance of: • Mandatory malnutrition screening • Nutrition assessment • Nutrition care planning • Food and nutrition systems • Menu planning • Meals and the mealtime environment (with 'National Meal Standards for residential aged care) • Assistance with eating and drinking • Staff nutrition education and ongoing training In terms of funding to implement and monitor the 'Nutrition Care Policy', minimum staff time standards for APDs in community and residential aged care are required. In British Columbia Canada, Aged Care Homes must have at least one registered dietitian who is a member of the staff and who is on site at the Home for at least 30 minutes per resident per month to carry out clinical and nutrition care duties. There must also be at least one designated Nutrition Manager for the Home. Where the registered dietitian for the Home is also a Nutrition Manager for the Home, any time spent working in the capacity of Nutrition Manager does not count towards the 30 minutes per resident per month time requirement for the registered dietitian. We recommend that similar mandatory EFT

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			ratios are introduced to ensure that all aged care recipients receive high quality nutrition care with dietetic care removed as an "optional" service. **Refer to Dietitians Australia's Position Statement on Malnutrition in Aged Care.**
A7	Once aged care homes have decided to address the issue of malnutrition, the complexity of causes can make it difficult to know where to put resources	Support the roll-out of an excellence ratings tool, which involves a multidisciplinary team conducting a detailed assessment over a couple of days, diagnosing the specific issues at a facility	As a fundamental principle of modern health care, prevention is better than cure. So as per the responses provided to A3 and A6, Australian Government investment in: • mandatory malnutrition screening; • reporting on 'malnutrition' in the National Aged Care Mandatory Quality Indictor Program; • implementation of a 'National Policy for Nutrition Care' in community and residential aged care; and • the establishment of minimum staff time standards for APDs in community and residential aged care; will address issues of malnutrition in aged care without the need to roll out an excellence ratings tool to assess/address issues of malnutrition. The implementation of malnutrition screening processes, a Nutrition Care Policy, together with mandatory EFT ratios for APDs is deemed the best approach to malnutrition management in aged care.

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A8	Referrals to allied health professionals (dietitians, speech pathologists, oral hygienists, dentists) need to be earlier for preventive health care	Provide education materials describing the role of allied health professionals in aged care and when referrals are appropriate	APDs work collaboratively with consumers and carers to maximise an individual's nutrition, function and quality of life. Unlike many other allied health professions, the role and responsibilities of APDs in residential aged care extends beyond individual clinical consultations. APD support in aged care is a mix of individual clinical care, management of food and nutrition systems and staff training. Therefore, it is important to consider not only the clinical care components, but also the systems management and staff training components. This is a vital consideration for APDs, which doesn't always affect other allied health professionals with a hands-on role (e.g. physiotherapists and occupational therapists).
A9	Nutrition care, oral care and swallowing care need to be part of the care plans for care recipients, with governance arrangements in place similar to other care requirements	How can the Department and/or the Commission assist in ensuring that these care requirements are treated in the same way as other care requirements?	APDs need to directly contribute to the care plans (both initial and evaluation) addressing nutrition care needs. Ideally, APD's are to be part of a Nutrition Care Working Group reporting to management and ultimately to the Governing Body (e.g. Board).

B. Consumer choice and dignity

No.	Issue to be addressed	Option/Question	Dietitians Australia feedback
B1	Providers often err on the side of caution in relation to risk feeding, thereby denying care recipients dignity and choice and the option to take risks	Enable a multidisciplinary team to develop a best practice framework to support informed choice in 'risk feeding'. This would include roles, responsibilities and legal considerations.	Dietitians Australia supports all providers having a risk management policy and framework in place that includes an APD, allowing consumers to make the best food choices despite the health risks. APDs can assist in the development of a best practice policy and framework to support informed choice in risk feeding. **Refer to Dietitian Australia's Position Statement on Consumer Choice and Dignity in context of food provided in aged care**

No.	Issue to be addressed	Option/Question	Dietitians Australia feedback
B2	Sometimes there appears to be a tension between food safety considerations and choice	Where does this tension come from? Will a 'risk feeding' framework address this tension, or are there other considerations?	The tension that may exist in delivering food and nutrition care consistent with evidence-based care is no different to tension around delivery of medications according to prescription, and delivery of general nursing care. The resident (supported by their families/next of kin) are centre to nutrition care and all food and nutrition decisions need to be made as a collaboration, following a formal 'Dignity of Risk' process. If residents choose not to follow the evidence-based guidelines that have been recommended, then this should be clearly documented in their progress notes. Where decisions about food choices are in question, an APD must attend the discussion with the consumer and family member enabling the best outcome for both the consumer and organisation.
B3	Facilitating care recipient communication and engagement	Communication and engagement can be facilitated by speech pathologists, occupational therapists and translators. Would education materials help with the uptake of these services?	No feedback to provide - this is outside the scope of dietetic care.

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B4	English language skills of care recipients are sometimes poor	How do we ensure that oral pain, food preferences and cultural considerations are effectively communicated?	Care residents should not have their care compromised through being unable to communicate in English. Dietitians Australia advocates for use of professional translation services, or where available, family members. This is the preferential method for obtaining information direct from the care recipient. Surrogate information may be obtained through discussions with other care staff (e.g. likes/dislikes), visual cues (e.g. food photos/pictures), and food availability (e.g. looking in the fridge/pantry) if the consumer still lives at home. It is important that food service staff are trained to maximise their communication with consumers too.
B5	In many aged care homes speech pathologists are not being engaged to provide advice on organisational tools and training in communication	How can the Department and/or the Commission increase the use of speech pathologists as communication consultants?	No feedback to provide - this is outside the scope of dietetic care.
B6	Recording and communication of all relevant information for a resident is often incomplete and knowledge transfer between care settings is often poor	Create a mealtime support passport template for use by providers, to appropriately capture all mealtime needs, including texture requirements, food preferences, individual support strategies, eating aides, cues for social interaction etc.	Dietitians Australia support this suggestion. Reviews should be conducted regularly (e.g. quarterly) to accommodate food preferences and texture requirements that may change over time. Dietitians Australia can assist in the development of a mealtime support passport template. **Refer to Dietitian Australia's Position Statement on Consumer Choice and Dignity in context of food provided in aged care**

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B7	Morning coffee and afternoon tea appear to be underutilised as opportunities for facilitated discussions and other activities	Would resources or education materials be helpful for improving the mid-morning and mid-afternoon mini-meal experience?	Dietary Guidelines for older adults do not currently exist, so it is vital that the NHMRC develop such guidelines as part of the current Australian Dietary Guidelines review – to inform food systems and menu planning in aged care. Dietary guidelines for older adults will then allow evidence-based 'National Meal Guidelines/Standards' (including governance and accountability frameworks) for residential aged care providers to be developed. Guidance for mid-meals, main meals, desserts and beverages will be underpinned by the National Meal Guidelines, and guide providers in the delivery of their food service. **Refer to Dietitians Australia's Position Statement on Food Production and Presentation in Aged Care**
B8	Many people eat the same thing for breakfast for decades, only for this option to be unavailable at their residential aged care home	How important is the breakfast menu to resident satisfaction? How can the Department and/or the Commission assist with this?	Ensure/mandate that all aged care providers include an Accredited Practising Dietitian (APD) in their multidisciplinary team to plan, implement and monitor food and nutrition services. APDs are skilled to identify food solutions that meet consumer's food preferences and work with catering staff and care staff to ensure resident satisfaction.
B9	Sometimes people regularly eat a particular snack, drink, dinner, meal etc. for decades, only for this to be unavailable at their residential aged care home	Does this need to be tackled separately from breakfast, or is the solution the same as for breakfast? How can the Department and/or the Commission assist with this?	Same response as to B8 - Ensure/mandate that all aged care providers include an Accredited Practising Dietitian (APD) in their multidisciplinary team to plan, implement and monitor food and nutrition services. APDs are skilled to identify food solutions that meet consumer's food preferences and work with catering staff and care staff to ensure resident satisfaction.

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B10	Evaluating and determining satisfaction is important and there may be insufficient tools available	Would it be beneficial to develop a validated questionnaire to review care recipient satisfaction with meals – home care and residential?	Such validated questionnaires already exist. For example, the *'Resident Foodservice Satisfaction Questionnaire'* developed by Queensland dietitians and published in a highly ranked international journal: DOI: 10.1007/s12603-010-0123-9 Tool development and validation is a time consuming process, and additional tools are not required where high quality tools already exist.
B11	Residents are limited to the choices offered to them	Are there particular food service styles that increase choice for residents? Should the Department and/or Commission be promoting these?	The number of choices on all institutional menus is limited by funding, staffing and the number of residents. The frequency of choices is also limited by the length of the cycle menu – a long cycle menu (with limited repetition) is likely to include less liked foods. Hence reducing the menu length (whilst decreasing choice) will mean that the most popular meal choices are available. Other options to consider are "a la carte" menus where the meal options repeat, but due to the absence of a cycle menu, options can be extended at each meal period, or the bedside meal ordering system which has revolutionised hospital nutrition care through improving dietary intake, satisfaction and reducing plate waste. DOI: 10.1111/1747-0080.12600.
B12	Activities related to cooking, gardening, and decorating the dining room can improve appetite and quality of life	How can the Department or the Commission facilitate the sharing of ideas to engage care recipients in these activities?	No feedback to provide - this is outside the scope of dietetic care.
B13	Gardening activities require plants and equipment	Would small grants to residential aged care homes to provide herbs, seeds, seedlings, plants and gardening equipment for the residents be helpful?	We agree that engaging residents in food and nutrition throughout the lifespan is likely to improve quality of life. We encourage some small grants to be funded for gardening projects that are formally evaluated to develop evidence on this topic. These should include a validated quality of life tool.

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B14	Music choice is cultural, generational and individual, and key to creating atmosphere	How do residential aged care homes consult with residents in the selection of music? Are educational resources required to assist with this? Would a collection of playlists be useful?	No feedback to provide - this is outside the scope of dietetic care.
B15	Technology for playing music might not be prioritised by aged care providers	Do residential aged care homes require financial assistance for sound technology?	No feedback to provide - this is outside the scope of dietetic care.
B16	There are a multitude of special cultural days, each with its own theme and associated food	Would a manual describing many of the events for the more common cultures of Australians be useful? For example, the decorations, music and food associated with different religious and cultural festivals?	Dietitians Australia support this suggestion. Ensure key cultural events/dates for Aboriginal and Torres Strait Islander people are included.

C. Nutrition

No.	Issue to be addressed	Option/Question	Dietitians Australia feedback
C1	Some of the literature claims that the nutrition screening tools available could benefit from an update	Is there benefit in reviewing the available nutrition screening tools, particularly in respect to the language used, to produce a more effective tool?	Multiple nutrition screening tools have been validated to indicate the nutritional status of adults in aged care settings. Screening tools are broadly considered to identify residents who are at high nutritional risk, whilst not requiring calculations, blood tests or measurement of anthropometric variables and are widely adopted in the acute care sector. The Malnutrition Screening Tool (MST) is an example of a validated tool for elderly people, widely used in Australia and easily adopted within residential and community aged care settings, with minimal training of staff.

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C2	Nutrition screening training material is unavailable	Develop e-learning modules for nutrition screening	Dietitians Australia support this suggestion. It is recommended that all aged care staff receive annual training (e.g. via an e-learning module) on how to identify and manage those who are truly at nutritional risk using a standardised process with a validated malnutrition screening tool. APDs can assist in the development and implementation of such e-learning modules. **Refer to Dietitians Australia's Position Statement on Malnutrition in Aged Care.**
C3	A significant number of those in home care are at risk of or have malnutrition	Pilot a nutrition screening program for home care recipients	Dietitians Australia support a pilot of routine malnutrition screening for home care recipients (1) at the assessment stage; (2) at the beginning of care; and (3) on a regular basis (i.e. quarterly re-screening). The pilot must include and evaluate training of home care staff on how to identify and manage those at nutritional risk using a standardised process with a validated malnutrition screening tool. Residents identified as being at risk of malnutrition or malnourished by the screening process are to be referred to an APD for nutrition intervention. **Refer to Dietitians Australia's Position Statement on Malnutrition in Aged Care.**

No.	Issue to be addressed	Option/Question	Dietitians Australia feedback
C4	Nutrition screening is important upon entry into residential aged care	Is the nutrition screening currently undertaken in residential aged care homes sufficient?	While malnutrition screening may occur on entry into residential aged care, ongoing re-screens are often ad-hoc. Quarterly re-screens must become embedded within standard procedures in aged care. Dietitians Australian maintains that results of quarterly re-screens of nutritional status must become the mandatory nutrition criteria and replace mandatory reporting on 'unintentional weight loss' in the National Aged Care Mandatory Quality Indictor Program. **Refer to Dietitians Australia's Position Statement on Malnutrition in Aged Care.**
C5	Nutrition screening questions could be on the forms used by the Aged Care Assessment teams (ACAT)	Review the ACAT assessment questions to ensure nutrition screening is included	Yes, a review of the nutrition screening questions in the ACAT is essential.
C6	Nutrition screening questions should be on the GP Health assessments for people aged 75 years and older	Review the questions for the Health assessments for people aged 75 years and older	Yes, a review of the nutrition screening questions in the Health Assessment for People 75+ years is essential.

No.	Issue to be addressed	Option/Question	Dietitians Australia feedback
C7	In a significant number of aged care homes dietitians are not being asked to provide advice on the food, nutrition and dining experience as a whole	How can the Department and/or the Commission increase the use of dietitians' complete skillset by more aged care homes? (See also F2.)	APD support in aged care is a mix of individual clinical care, management of food and nutrition systems (including foodservice systems) and staff training. It is proposed to establish minimum staff time standards for APDs in community and residential aged care. In British Columbia Canada, Aged Care Homes must have at least one registered dietitian who is a member of the staff and who is on site at the Home for at least 30 minutes per resident per month to carry out clinical and nutrition care duties. There must also be at least one designated Nutrition Manager for the Home. Where the registered dietitian for the Home is also a nutrition manager for the Home, any time spent working in the capacity of nutrition manager does not count towards the 30 minutes per resident per month time requirement for the registered dietitian. We recommend that similar mandatory EFT ratios are introduced to ensure that all aged care recipients receive high quality nutrition care with dietetic care removed as an "optional" service. **Refer to Dietitian Australia's Position Statement on Aged Care Staff Skills and Training.**
C8	There appears to be an overuse of supplements and food alternatives in residential aged care	Review the guidelines associated with nutrition care to ensure that compliance with Quality Standards includes the expectation that a dietitian is involved in nutrition care planning before routine use of supplements and food alternatives	Dietitians Australia fully support this approach, as this recommendation is at the core of the **Dietitians Australia's Position Statement on Malnutrition in Aged Care.**

No.	Issue to be addressed	Option/Question	Dietitians Australia feedback
C9	When residents don't eat, there are many possible reasons	Providers need to have systems in place so that not eating triggers an investigation into why, including environmental factors, food preferences and screening for oral health, swallowing and nutrition, followed by referral or further investigation. How can the Department and/or the Commission increase the effectiveness of detection and escalation processes?	Mandate that aged care providers include APDs in: - Aged Care Assessment Teams; - wound care services; - dementia care teams; and - community education programs directed at reducing the risk of malnutrition, falls and wounds, to support older people and to guide other workers in nutrition care. **Refer to Dietitian Australia's Position Statement on Aged Care Staff Skills and Training**

D. Oral health, swallowing and hydration

No.	Issue to be addressed	Option/Question	Dietitians Australia feedback
D1	The IDDSI system is relatively new and has not been fully implemented across aged care	Bring together a multidisciplinary collaborative group led by clinical experts to enable IDDSI implementation. This could explore technological options, recipes and presentation techniques	Dietitians Australia fully support this approach. Dietitians Australia will be a key collaborator in this, with assistance from aged care experienced APDs to advise on training, recipes and presentation techniques. **Refer to Dietitian Australia's Position Statement on Oral Health, Swallowing & Hydration in Aged Care**
D2	Oral health of older people tends to decline in the year prior to entering residential aged care	What can be done about this? (Could an option be around home care screening for oral health?)	No feedback to provide – experts from dental and oral hygiene professions are best to advise on this.
D3	The oral health question on the forms used by the Aged Care Assessment teams (ACAT) do not seem to result in the identification of all those who require dental care	Review the ACAT assessment questions and modify to use more direct language	No feedback to provide – experts from dental and oral hygiene professions are best to advise on this.
D4	Oral and dental health questions could be on the GP Health assessments for people aged 75 years and older	Review the questions for the Health assessments for people aged 75 years and older	No feedback to provide – experts from dental and oral hygiene professions are best to advise on this.

No.	Issue to be addressed	Option/Question	Dietitians Australia feedback
D5	It is currently not routine practice to for aged care residents to see a dentist (when a dentist is available) upon entry to a residential aged care home and to be involved in residents' oral care planning	Review the guidelines associated with dental care to ensure that compliance with Quality Standards includes the expectation that a dentist is involved in oral care planning wherever possible and teeth are cleaned twice daily	No feedback to provide – experts from dental and oral hygiene professions are best to advise on this.
D6	Residential facilities often don't have appropriate treatment rooms for medical and dental care (running water, no carpets etc.)	Provide financial assistance to residential aged care homes to establish designated treatment room/ dental surgery	No feedback to provide – experts from dental and oral hygiene professions are best to advise on this.
D7	Referrals to oral hygienists and dentists are often much later in disease progression than is ideal	Promote the use of the oral health assessment tool already developed	No feedback to provide – experts from dental and oral hygiene professions are best to advise on this.
D8	Oral hygiene often deteriorates upon entry to residential aged care	Design and develop online education materials on oral hygiene strategies for personal care workers	Dietitians Australia support this approach, with nutrition strategies to support oral health included as well.
D9	Dysphagia is not identified sufficiently early and referrals to speech pathologists tend to be too late for proactive strategies	Design, develop and pilot a dysphagia and communication screening tool	Dietitians Australia support the use of evidence based validated tools. Such a tool may already be available, and this should be determined prior to the commissioning of a new tool.
D10	Aged care staff have not received appropriate training on dysphagia and the importance of referral and strategies	Design and develop online education materials for all aged care staff on meeting the needs of those with dysphagia	Dietitians Australia support this approach. Online education material must outline the vital role of APDs in the management of dysphagia. Dietitians Australia can assist in the developed of such training material. Furthermore, the development of evidence-based 'National Meal Guidelines', including governance and accountability frameworks, is needed for quality and safety within residential aged care. In relation to oral health, swallowing and hydration, these guidelines will support implementation and evaluation of the International Dysphagia Diet Standardisation Initiative (IDDSI) guidelines. **Refer to Dietitian Australia's Position Statement on Oral Health, Swallowing & Hydration in Aged Care**

No.	Issue to be addressed	Option/Question	Dietitians Australia feedback
D11	Hydration is important	Are there any issues related to hydration that the Department could help improve?	Meeting the hydration needs of aged care consumers also remains challenging. Recommendations for fluid intakes are approximately 1.5L daily, yet achieving this target can be compromised through issues including cognition and dysphagia.

E. Menu planning and innovation

No.	Issue to be addressed	Option/Question	Dietitians Australia feedback
E1	Recipes and menu design are often important intellectual property, but there would be considerable value in these being shared	How can the Department or the Commission facilitate the sharing of recipes and menu designs?	A shared database of recipes and menus would definitely save duplication of work. Acknowledging the developer of recipes and menus is appropriate, with facilities acknowledged for their contribution.
E2	The Australian Dietary Guidelines are used by most aged care homes, yet they explicitly exclude the majority of the residential aged care demographic	The Australian Dietary Guidelines are being reviewed by the NHMRC. Would it be beneficial to develop separate guidelines for the 70+ demographic?	The development of Dietary Guidelines for Older Australians (70+ years) is essential to inform food systems & menu planning in aged care. Evidence-based 'National Meal Guidelines' for aged care providers cannot be developed without Dietary Guidelines for Older Australians. **Refer to Dietitian Australia's Position Statement on the Importance of Food in Aged Care**

No.	Issue to be addressed	Option/Question	Dietitians Australia feedback
E3	There is no national nutritional guidance for aged care providers	Victorian and Queensland aged care homes use the Victorian or Queensland nutritional standards. Is there a need for the Australian Government to provide national nutritional guidance for aged care, based on these standards?	Urgent investment is needed to develop evidence-based 'National Meal Guidelines/Standards', including governance and accountability frameworks, for residential aged care providers. The development of governance, monitoring and evaluation frameworks for the existing 'National Meal Guidelines for Home Delivered and Centre-based Meal Programs for Older Australians' is also required. **Key considerations for the 'National Meal Guidelines' are outlined in Dietitian Australia's Position Statement on Menu Planning and Innovation in Aged Care**
E4	Recipes for aged care need to be analysed for nutritional value	Is this something that staff who are not dietitians or nutritionists should be able to do? Are tools and further information about conducting recipe analyses required? Is training required for a specific profession e.g. chefs?	Recipe analysis and interpretation of results along with nutritional assessment and management are core skills included in the training of dietetic professionals. A high quality menu analysis (including analysis of recipes at an individual) can be completed by APDs.
E5	Nutrition requirements during palliative care are different	What type of nutrition information or guidelines would be helpful for palliative care? Who should the information be designed for?	Nutrition information is freely available on the internet regarding nutrition requirements for palliative care. This includes from Palliative Care Australia and some state health services (e.g. Queensland Health). This information could be tailored into materials for aged care providers.
E6	Everyone has favourite foods and cultural preferences	Are tools required to discover residents' favourite and/or cultural foods? Do we need to publish hints and tips for incorporating preferences into the menu?	No special tools are needed, although the 'nutrition passport' described earlier would ensure a standard approach to data collection and transfer.

No.	Issue to be addressed	Option/Question	Dietitians Australia feedback
E7	Menu design and the presentation of the menu are complex processes	Develop a best practice guide for menu design and presentation, including the design of texture modified menus and the presentation of menus using a careful choice of language and appropriate pictures, considering those from non-English reading backgrounds	The proposed 'National Meal Guidelines/Standards' (see E3) must include a best-practice guide for menu design and presentation, including the design of texture modified menus and the presentation of menus using a careful choice of language and appropriate pictures, considering those from non-English reading backgrounds. **Refer to Dietitian Australia's Position Statement on Menu Planning and Innovation in Aged Care**
E8	Many residential aged care home menus do not currently contain pictures	Creating appropriate pictures on menus can be tricky. Do residential homes require financial assistance to develop a library of photos of the food served at the home?	There are validated published methods to develop photo images for inclusion in menu books or for a pictorial record via a digital device. Collection of the images should be conducted over one full cycle of a menu (including all meals during weekdays and weekends). Costs include a white canvas and tripod, and a smartphone can be used. The costs for these items (excluding a smartphone/camera) are minimal (<$10) and should not need special funding.
E9	Many residential aged care home menus do not currently contain picture icons	Would a library of icons representing different foods help in communicating the menu to residents?	The need for menu picture icons has not been established in the literature.
E10	Many residential aged care home menus are only provided in English	Are menus translated into different languages for residents in some aged care homes? Would it be beneficial for this to happen more often? Are additional resources required for this? If so, what type of resources?	The translation of menus into languages other than English, where there are residents whose first language is not English, is encouraged. A centralised system may be the most efficient mechanism for doing this to save many homes paying for translation of menu items. Equally, the use of freely available translation searches such as "Google Translate" may mean that homes can manage this process for no cost locally.

F. Dining experience and mealtimes

No.	Issue to be addressed	Option/Question	Dietitians Australia feedback
F1	The breadth of subjects related to food, nutrition and the dining experience is not fully covered in available manuals (see information in pre-reading deck)	Would this information gap be provided by *National meal guidelines*? What is the best way of providing the necessary information?	Yes, the 'National Meal Guidelines/Standards' would certainly fill this gap. Training options (e.g. e-learning modules and/or face-to face training delivered by APDs) on the National Meal Guidelines will be vital to a successful rollout. **Refer to Dietitian Australia's Position Statement on Menu Planning and Innovation in Aged Care**
F2	Not all aged care homes are assessed by a dietitian using the tool *Menu and mealtime quality assessment for residential aged care*	How can the Department and/or the Commission promote the assessment by an independent professional of the menu and mealtime experience? (See also C7.)	The Department and/or Commission could include a requirement that the assessment of menus (for all diet types) and the mealtime experience must be completed by an independent APD. Furthermore, the Department and/or Commission could endorse and promote Dietitian Australia's *'Menu & Mealtime Quality Assessment for Residential Aged Care'* (MMQA-RAC) as the best-practice assessment and provide training to its assessors on the assessment. The RAC assessment form could be amended to require assessors to review the MMQA-RAC report to ensure recommendations have been actioned. **Refer to Dietitian Australia's Position Statement on Mealtimes & the Dining Experience in Aged Care**
F3	Staff need to eat too, and there is evidence that staff eating with residents is beneficial to the residents	How can the Department and/or the Commission promote staff eating with residents?	Key staff groups that eat with those they care for (e.g. childcare, kinder) are likely to contribute valuable insights to this discussion.
F4	The design of dining rooms is often sub-optimal	Would grants to aged care providers for dining room redesign be beneficial?	Some dining rooms may benefit from re-design, but investment in privately owned residential care facilities may not be the priority for expenditure.
F5	Specialised eating utensils, crockery and place settings are often beneficial	Would grants to aged care providers for specialised eating utensils etc. be beneficial?	Yes, dependent on the advice of occupational therapists.

No.	Issue to be addressed	Option/Question	Dietitians Australia feedback
F6	Residents of aged care homes often require assistance with eating	What incentives can be provided so that residents are given sufficient assistance with eating? What should be the regulatory expectations?	There should be sufficient funding to allow all consumers to have their meal at a similar time. This will mean that more staff will need to be rostered at the mealtime so that some consumers don't have to have their meal up to an hour before others. Assistance with eating is a mandatory role for nursing and care staff employed in residential aged care facilities. This should be included in all mandatory standards and the delivery against this standard should form part of the accreditation process.
F7	Responsibility for the dining room (ambience, music, aromas, table settings, cleanliness) is often not explicitly allocated	How can the Department and/or the Commission ensure that the dining room is not overlooked by facility management?	Management of the dining room should form part of any contractual arrangements.
F8	There is often a lack of nutritious food available between dinner and breakfast	How can the Department and/or the Commission ensure the availability of food during the evening and night? Should this be a regulatory expectation?	Yes, it should be a regulatory expectation that accessible snack options are available at any time of the day or night and a 24 hour menu service is available for those away from the facility at usual meal times (i.e. meals are available on their return from hospital/outings). There should be sufficient food and a range of different foods – as observations are that currently it's just sandwiches or pureed fruit.

No.	Issue to be addressed	Option/Question	Dietitians Australia feedback
F9	There are reports of snacks of low nutritional value being routinely used in aged care facilities	Is this an educational issue?	Snacks form an essential part of the daily intake for aged care residents. The use of snacks with low nutritional value (e.g. commercial biscuits) is a lost opportunity to meet nutritional requirements. This is likely an educational issue, but also a cost issue, as residential aged care menu costs as are well known to be as little as $6 per resident per day. We should ensure/mandate that all aged care providers include an Accredited Practising Dietitian in their multidisciplinary team to plan, implement and monitor food and nutrition services. APDs are skilled to identify food issues and implement nutrition solutions that meet nutritional needs and consumer food preferences.

G. Food production and presentation

No.	Issue to be addressed	Option/Question	Dietitians Australia feedback
G1	In some aged care homes it is reported that food is overcooked because of misunderstanding food safety requirements	Do we need more materials interpreting the food safety requirements? Is it the chefs and cooks who need training? Are managers insisting on this? How do we stop this practice?	The proposed 'National Meal Guidelines/Standards' will address this. **Refer to Dietitian Australia's Position Statement on Menu Planning and Innovation in Aged Care**
G2	Kitchen design is important	Is there a need for kitchens to be redesigned in residential aged care homes? Would grants to aged care providers assist with this?	No feedback to provide - this is outside the scope of dietetic care.
G3	Specialised equipment is required to meet food safety requirements and produce texture modified food	Would grants to aged care providers with specialised equipment be of assistance?	Dietitians Australia support this – along with support for staff to be trained to use the specialised equipment.

No.	Issue to be addressed	Option/Question	Dietitians Australia feedback
G4	There are considerable documentation requirements related to the kitchen	How important is software for documentation? Should the Department assist with the roll-out of software, hardware or training?	The software that is used in the kitchen must be food focused and interface with the clinical consumer records. This will enable accuracy and efficiency for the whole team. It may be the same as the consumer clinical record, but it is usually not very useful for the kitchen team.
G6	Sustainability is important	The NSW Government has a *Sustainability Advantage* scheme. Has this scheme been beneficial to aged care? How could the Department and/or the Commission promote sustainability?	Australian Government to further support Aged Care Providers with incentives (like Sustainability Advantage) to integrate sustainable practices into their foodservice operations, such as strategies to reduce food waste and water usage, to reduce the impact of the expanding aged care industry on our environment. **Refer to Dietitian Australia's Position Statement on Food Production and Presentation in Aged Care**
G7	In rural areas the cost of food can be greater than in cities	Does the additional cost of food in rural areas make food provision in rural areas significantly more difficult than in cities?	There has been considerable research conducted on the excessive food costs in rural areas, particularly in Indigenous areas. Costing mechanisms should accommodate these additional costs to ensure that the diet of residents in rural areas is not compromised.
G8	Pre-packaged food and beverage can be difficult to open by the elderly	Is this an issue for residential care, or is it only an issue in home care? Would guidelines in relation to the ease of opening of food and beverage packaging be helpful?	The use of portion controlled food in facilities is problematic and research in hospitals has found that packaging impedes nutritional intake. Guidelines would be useful, however minimising the use of pre-packaged foods (which would also reduce the non-food waste) is preferable.

H. Staff skills and training

No.	Issue to be addressed	Option/Question	Dietitians Australia feedback
H1	Training needs for home care food delivery services such as meals on wheels	Are there specific training materials that would be beneficial for home care providers of meals?	While 'National Meal Guidelines' for service providers, caterers and health professionals providing home delivered and centre-based meal programs for older Australians already exist, there are no governance, monitoring and evaluation frameworks in place to ensure the guidelines are being followed. As such, it is recommended that the Australian Government urgently fund the establishment of governance, monitoring and evaluation frameworks for the existing National Meal Guidelines for home delivered meal programs for older Australians. **Refer to Dietitian Australia's Position Statement on Menu Planning and Innovation in Aged Care**
H2	There is no weekly community of practice for home care meal providers	Would it be beneficial to home care meal providers to connect online in a facilitated discussion on a weekly basis?	Possibly – with an APD included to address/problem solve nutrition issues raised as part of the discussions.
H3	There is no weekly community of practice for residential aged care workers involved in food and nutrition	Would it be beneficial to residential aged care workers to connect online in a facilitated discussion on a weekly basis?	Perhaps this could be facilitated by the LHN, so that the discussion is more local. There could be a wider group that meets less frequently. It will be important to include an APD in facilitated discussions to address/problem solve nutrition issues raised as part of the discussions.

No.	Issue to be addressed	Option/Question	Dietitians Australia feedback
H4	Chefs in aged care require specific nutritional knowledge and texture modification preparation techniques	Are there sufficient educational materials and training courses available for chefs in aged care? Does the training available for new chefs enable specialisation in aged care?	It is recommended to build competency of chefs in aged care by including food and nutrition skills in the core content of vocational education training (VET) qualifications for chefs and foodservice staff. This will ensure graduates have adequate food and nutrition knowledge and skills to support their clients. It is further recommended to introduce a new accreditation requirement that all aged care workers (including chefs and food service staff working in residential aged care, day programs, respite care and community care) must complete training modules on food, nutrition and the dining experience annually, to keep nutrition knowledge and skills current. Training is to be provided by approved professionals (e.g. APDs). **Refer to Dietitian Australia's Position Statement on Aged Care Staff Skills and Training**

No.	Issue to be addressed	Option/Question	Dietitians Australia feedback
H5	Nursing, aged care management and Certificate III and IV aged care qualifications often contain limited content related to oral health care and nutrition	There has been considerable work in this area with the Aged Services Industry Reference Committee and the *Nutrition and the mealtime experience* advisory committee. Is there further action the Department should be considering?	Introduce funding to support annual in-house nutrition training for all aged care staff and support workers working in residential aged care, day programs, respite care and community care (as part of annual CPD requirements) to keep nutrition knowledge and skills current. APDs are the experts to develop and deliver this nutrition training. Funding should support maintenance of services at acceptable levels to older people while workers are off the floor for training. It is also recommended to develop and implement food and nutrition training for accreditation surveyors from the Aged Care Quality and Safety Commission with input/guidance from APDs experienced in aged care. **Refer to Dietitian Australia's Position Statement on Aged Care Staff Skills and Training**
H6	Turnover of staff is often high	What would assist in retaining staff? Should high staff turnover be a flag for Commission assessors and accreditors?	Introduce new models and innovative approaches to student placement experiences in the aged care sector for allied health professionals, including dietitians, in training. For example, change Medicare and DVA health care arrangements to allow allied health students on placement to deliver part of the service when supervised by a qualified allied health care professional. The current system is a major barrier to supporting students in exposure to practice in aged care, and to gaining skills and knowledge in aged care to prepare them for practice after graduation. **Refer to Dietitian Australia's Position Statement on Aged Care Staff Skills and Training**