Response ID ANON-4U3B-FQEZ-M

Submitted to **Single Aged Care Quality Framework - Draft Aged Care Quality Standards**
Submitted on **2017-04-21 19:41:53**

Introduction

1 What is your email address?

Email:
policy@daa.asn.au

2 Are you answering on behalf of an organisation? If so, please provide your organisation's name.

Yes

Organisation:
Dietitians Association of Australia

3 Do you give consent for your submission to be published in whole or in part?

Yes

More detail about you

4 What role best describes you? Please select all that apply.

Peak body - professional

Text box to add other roles:

5 Do you identify with any special needs groups, or, does your organisation provide support or services to any special needs groups? Please select all that apply.

6 Where do you live, or, where does your organisation operate? Please select all that apply.

NSW, VIC, QLD, WA, SA, TAS, ACT, NT

7 What is your location, or, the location where your organisation operates. Please select all that apply.

Metropolitan, Regional, Rural/Remote

8 If you are an aged care service provider, please select all the types of care your service delivers.

9 If you are an aged care service provider, which option below best describes the size of your organisation?

Not Answered

General questions about the draft standards

10 Do the consumer outcomes in the draft standards reflect the matters that are most important to consumers?

Yes, mostly

Text box for suggestions about improving consumer outcomes:
A new set of quality standards that will apply to all aged care services welcome. DAA has viewed previous standards as being inadequate. There is an opportunity in the design and implementation of new standards to address risk of harm related to nutrition, improve consumer health and wellbeing, and improve consumer and carer experience of services in aged care.

The key themes are reasonable. DAA would like to see greater emphasis on nutrition risk to provide guidance to organisations and assessors. Food and nutrition related considerations have been incorporated into Version 2 of the ACSQHC NSQHS Standards. DAA would like to see a similar approach in the aged care standards. This is important for residential care where frail older people may have little or no independent ability to access food and fluids to maintain health and wellbeing. It is also important for consumers receiving services in the community as they too may have limited ability to independently access food and fluids, and whose health and wellbeing is impacted by poor nutrition. Malnutrition is an accelerator to residential care, so consideration of nutrition risk in all community and residential care settings should be addressed by the Standards.

11 Are the organisation statements and requirements in the draft standards achievable for providers?

Yes, mostly

Suggestions - are organisational statements and requirements achievable:
Feedback to DAA by Accredited Practising Dietitians and service providers is that cost is an issue in employing or bringing in consultant Accredited Practising Dietitians to advise on food and nutrition systems. This places in doubt the capacity of organisations to meet Standard 7 in terms of professional standards and guidelines. Having strong sufficiently detailed standards which are rigorously assessed is critical to achieve safe and quality care.

12 Are the draft standards measurable?

No

Text box - suggestions are draft standards measurable:
It is difficult to answer this question without also having the supporting/guidance material available.

13 Are there any gaps in the draft standards? If so, what are they?

Yes

Text Box for gaps in draft standards:
The standards as presented do not adequately reflect nutrition risk, the management of which requires cooperation across the organisation with input from various stakeholders . DAA would like to see nutrition and hydration stated explicitly in the standards, with the detail of this in supporting/guidance material. The content could look very similar to the food and nutrition content in the NSQHS Standards to provide better guidance to organisations and assessors.

Regarding standard 5, the standard is presented as physical environment but a safe environment now implies a culturally safe environment also.

14 Is the wording and the intent of the draft standards clear?

Yes, mostly

Text box for suggestions about how wording and intent could be improved:
Comments are made with respect to individual standards.

15 Are any draft standards or requirements NOT relevant to the following services? If so, please provide details below.

Text box reason why stanard is not relevant:
DAA considers that food and nutrition systems are relevant to all of these services.

Specific suggestions about each draft standard

16 Do you have any specific suggestions in relation to draft Standard 1: Consumer dignity, autonomy and choice? If so, what are they?

Text box Standard 1 Consumer dignity, autonomy and choice:
Standard 1.4. DAA supports statement 1.4. Choice is very relevant to food and nutrition systems, not least in terms of menu design and implementation, but also in processes of consumer decision making with respect to choices which may place them at risk. Ideally organisations will have staff with the skills of supported decision making and in assessing individual clinical risk. Traditionally staff in an organisation might order a diabetic diet, or modified texture diet, for a consumer but without considering the wishes of the consumer and without considering the overall nutrition needs of the consumer leaving them vulnerable to malnutrition. it is important that both clinical need and choice are considered in a holistic manner by well trained staff with access to professional advice where needed, in this case to an Accredited Practising Dietitian.

Standard 1.5 Information provided to consumers. DAA supports statements 1.5 a. and b. and suggests that testing of messages by consumers, organisations, health professionals and other stakeholders be undertaken to ensure information provided meets the needs of the intended audience.

P16 Identity, culture and diversity is very important to food and nutrition systems which meet the needs of consumers.

17 Do you have any specific suggestions in relation to draft Standard 2: Ongoing assessment and planning with consumers? If so, what are they?

Text box suggestions in relation to draft Standard 2: Ongoing assessment and planning with consumers:
Standard 2 Ongoing assessment and planning with consumers is also highly relevant to food and nutrition systems which meet the needs of consumers.

18 Do you have any specific suggestions in relation to draft Standard 3: Delivering personal care and/or clinical care? If so, what are they?

Text box suggestions in relation to draft Standard 3: Delivering personal care and/or clinical care:
3. Delivering personal care and/or clinical care. Malnutrition, dehydration and choking are appropriately recognised as risks. Other nutrition risks which should be recognised are food allergy and intolerance, and special dietary requirements e.g. for renal failure (noting that in individual situations there should be consideration of the overall dietary requirements for health and wellbeing, and the choice of the consumer with respect to acceptance of risk of harm of not following advice).

DAA would like to see detailed guidance for organisations related to quality in food and nutrition systems, similar to those which have been included in the NSQHS Standards. Whereas the average length of stay in hospital is 5.7 days, residents in aged care experience food and nutrition systems over an extended time, with 44% calling residential care their home from 1 to 5 years. Older people receiving services are often vulnerable and unable to meet their needs independently with respect to nutrition and hydration which makes it even more important that the services they receive consider their needs.

3.8 Malnutrition and dehydration. ‘Organisations that provide residential care would be expected to manage these risks for each consumer’. DAA considers these and other nutrition risks will be experienced by consumers in respite care, transitional care, home care as well as residential care and this should be reflected in the standards. The meaning of ‘manage’ is not clear, we suggest clarifying e.g. manage includes the concepts of prevention, identification (i.e. screening and assessment), intervention/treatment, monitoring/evaluation.

P21. Unexpected deterioration or change is appropriately identified. However, there should be recognition also of deterioration over a longer time e.g. unplanned weight loss which continues.

19 Do you have any specific suggestions in relation to draft Standard 4: Delivering lifestyle services and supports? If so, what are they?

Text box suggestions in relation to draft Standard 4: Delivering lifestyle services and supports:
P24 Delivering lifestyle services and supports includes food services. Cultural and social aspects of food and nutrition systems are important and this should be reflected in the supporting/guidance material for this standard, along with consideration of nutrition risk. We suggest modelling material in the supporting/guidance material be modelled on that of the NSQHS Standards which is comprehensive and mostly relevant to the aged care standards.

The Dietitians Association of Australia would be pleased to contribute to the drafting of the supporting material.

Organisations should consider the needs of their consumer population as a whole in designing systems to meet consumer needs, and this should form a platform for delivery of individual services to meet clinical needs. While some consumers will benefit from special diets, their overall wellbeing must be considered. For example, a modified texture diet ordered in isolation may place the consumer at risk of malnutrition, which in turn adversely impacts on dysphagia and immune integrity. A diet for diabetes which is appropriate for a middle aged ‘well’ person is not appropriate for an elderly person with dementia whose intake is poor.

Having appropriate health professional direction is also important and this should be reflected in the supporting/guidance material. For example, food and nutrition systems should be supported by multi-disiciplinary groups, with Accredited Practising Dietitians and consumers as key contributors.

20 Do you have any specific suggestions in relation to draft Standard 5: Service environment? If so, what are they?

Text box - specific suggestions in relation to draft Standard 5: Service environment:
The physical environment is important with respect to food and nutrition systems. Having pleasant function eating environments with appropriate aids, equipment and staffing is essential. this should be reflected in supporting/guidance material.

21 Do you have any specific suggestions in relation to draft Standard 6: Feedback and complaints? If so, what are they?

Text box suggestions in relation to draft Standard 6: Feedback and complaints:
This standard is important as food can be a source of complaint by consumers or carers. Good practice in food and nutrition systems involves regular auditing as well as a well functioning feedback and complaints system.

22 Do you have any specific suggestions in relation to draft Standard 7: Human resources? If so, what are they?

Text box suggestions in relation to draft Standard 7: Human resources:
DAA supports items 7.1 – 7.5 and sees it as highly relevant to the workforce engaged at different points of a food and nutrition system e.g. dietitian, food service manager, cook, chef, kitchen hand, nurse, care worker, etc.

Food and nutrition skills are relevant across care settings e.g. if a person has in-home support with meals the care worker must have basic food and nutrition skills. This has been identified as an area of need in aged care.

23 Do you have any specific suggestions in relation to draft Standard 8: Organisational governance? If so, what are they?

Text box - suggestions in relation to draft Standard 8: Organisational governance:
Supporting/guidance material should support the involvement of multidisciplinary teams in compliance with requirements, continuous improvement and risk management. This is especially important in food and nutrition systems where food and nutrition is everybody's business but nobody's business. Leadership should include relevant professionals, e.g. Accredited Practising Dietitians in food and nutrition systems.

Other Comments

24 Do you have any other comments or suggestions about the draft standards?

Text box - any other comments or suggestions:
The intention is to see relationships between standards. This is absolutely essential to food and nutrition systems which cross both clinical/personal care and lifestyle sections of the standards, and other standards. We expect that organisations delivering residential care will be able to approach food and nutrition systems in an integrated manner without much difficulty.
There may be a challenge is where an organisation may not have to meet some of the standards. DAA wants to see adequate consideration of food and nutrition safety and quality wherever food is part of the consumer experience in the community. For example, an organisation delivering a day care program providing meals should comply with the standards relevant to food and nutrition quality and safety, and should be assessed on those standards. Standard 3 currently includes food services, and so organisations providing in home support with meals, day programs, respite, residential care should comply with Standard 3. Aspects of other standards are also relevant to food and nutrition systems e.g. choice so this should considered in determining with which standards an organisation must comply.

A third challenge relates to having a workforce with adequate training and hours to implement care which is safe and of an agreed quality.