



Review of National Aged Care Quality Regulatory Processes

July 2017

The Dietitians Association of Australia (DAA) is the national association of the dietetic profession with over 6000 members. 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 Review of National Aged Care Quality Regulatory Processes by the Australian Government Department of Health.

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DAA interest in this consultation

DAA has a continuing interest in the physical and emotional wellbeing of older Australians living in residential aged care facilities, and finds the reports of poor care at Oakden¹ and in other facilities distressing. Access to food is a basic human right² and as the peak body for nutrition professionals in Australia, DAA considers that current regulatory processes do not ensure that frail older Australians receive adequate food and fluids which are enjoyable and which meet physical and emotional needs.

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 and food service 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 and mental health facilities.

Summary

Poor nutrition compounds poor mental health and accelerates physical decline³. Current regulatory processes do not adequately protect frail older people, particularly with respect to food and nutrition. Better aged care standards and accreditation processes are needed to support food and nutrition systems which serve the interests of older people. Better training is needed of accreditors, and employees of facilities, along with greater investment in food and nutrition systems to promote wellbeing and quality of life for older people.

Key messages

The Oakden Report

Regarding the Oakden Report, it seems that issues related to food, nutrition and dietetic care have not been considered sufficiently. There is mention of 'cold food', but no other comment on food even though food and fluids which are enjoyable are essential to meeting the physical and mental health needs of residents. There is mention of weight loss in one resident but without further comment or connection to nutrition as a risk factor in falls.

We are aware that after the Stafrace and Lilly report on Oakden in 2008⁴, dietitians were contracted to address inadequacies in food and nutrition systems but those services were later terminated by management. In the current report, 'dietitian' appears on a staff list, and a vacancy in that position noted by the Community Visitor. We have no issue with the authors of the report identifying the need for particular allied health disciplines, but there is inadequate recognition of the importance of food and nutrition for the wellbeing of residents, along with the role of dietitians as contributors to multidisciplinary care, and leaders in food and nutrition systems.

We acknowledge that there are a number of issues which the authors of the Oakden Report were to address, but it is concerning that nutrition has not been dealt with more completely.

Should legislation impose financial penalties?

The Aged Care Act 1997 could be considered to fail in so far as it does not impose penalties for failure under the act unless another law has been broken. Having provisions in legislation to impose financial penalties could act as a stick to raise the performance of poor performers. We suggest however that penalties will likely be of little benefit without better accreditation standards, more training of accreditors and employees of providers, and greater investment in food and nutrition systems.

Better standards

The poor attention to nutrition in Australian aged care standards is hard to understand given food is a human right. The consequences for residents are poor quality of life, and increased morbidity and mortality. Sadly, the prevalence of malnutrition in aged care facilities remains unacceptably high in published Australian studies, as listed in the Attachment.

Consequently, DAA has been advocating for some time for standards which provide real guidance about adequate food and nutrition for older people in care. In the case of Oakden the NSQHS standards were used but these are silent on the subject of nutrition. DAA has been critical of this fact, and has been working closely with the Australian Commission on Safety and Quality in Health Care to include nutrition risk and relevant material in draft Version 2 of the NSQHS.

In terms of the current Aged Care Standards, these refer only to 'provision of adequate food and fluids' but feedback from APDs and the statistics in Australian studies indicate this is inadequate to guide service providers or accreditors. DAA considers the accreditors should be assessing care using prompts such as those suggested in the Appendix. For example, does the facility provide choice of food to residents, ensure food is served at an appropriate temperature, and that assistance is provided to eat etc.

The development of the Single Quality Framework offers an opportunity to address the scant attention to nutrition and hydration in aged care accreditation. Given the draft Framework mentions malnutrition only once, DAA has taken the initiative to offer assistance to AACQA with a view to including robust Guidance Material to support the Single Quality Framework which can assist service providers and accreditors to implement and maintain well-functioning food and nutrition systems.

In 2013 the NSW Health Agency for Clinical Innovation released Nutrition Standards for consumers of mental health services in NSW⁵ but we are not aware of similar standards being adopted in South Australia.

Reporting of poor performance

The Aged Care Complaints Commissioner is one of the elements of the aged care quality regulatory process. In 2014-15 there were over 500 complaints identified as being about food. Other complaints might also reflect on the quality of food and nutrition systems, such as falls, health and personal care, infections and continence management. Clearer reporting could assist with understanding the depth and breadth of poor quality care and the connections between contributing components.

Better training of accreditors

Food and nutrition systems are complex even in small facilities and yet accreditors rarely have a background in food and nutrition systems. We understand also that AACQA accreditors have not received training in nutrition for some considerable time.

Anecdotally, APDs report that accreditors interpret the current Aged Care Standards inconsistently. For example, one provider who generally performs very well with respect to provision of food and nutrition, was found not to have met the Standards because a resident with dementia with very difficult behaviour refused a variety of food and nutrition supplements and the facility was marked down because the resident was very underweight. And yet facilities which have passed accreditation are later found to be so poor that sanctions are applied.

The implementation of the Computer Assisted Accreditation Tool by AACQA is a step in the right direction to support more consistent accreditation, but better standards will be needed for the Tool to work. It is hoped that over time an accumulated database will enable interrogation of accreditation data to inform better care.

Attitudes about care

Well intended service providers say 'it is not a hospital, it is their home' when APDs call for stronger standards. It is no doubt because there is a misunderstanding that APDs want to be prescriptive about nutrition care. Actually, the opposite is true. In many respects the frailty of older people means the priority is that residents should receive enjoyable nutritious food. The resident, where possible, should be empowered to choose the level of nutrition risk consistent with the philosophy of consumer directed care. Moreover, the reason DAA advocates for stronger standards is that in residential care, older people may experience poor quality food 24/7 with little recourse to additional quantities of food or greater choice of food⁶. One might consider the lack of access to nutritious food in appropriate quantities to be a form of elder abuse.

At present staff who deliver residential care, as care workers or food service workers are generally not highly educated nor well paid, and they are often not in a good position to advocate for better care of residents. In other cases, agency nursing staff may be well trained but may not know how to advocate for residents when they are covering one or two shifts in a facility. Much more work is needed to empower staff to advocate for residents, and to contribute to multidisciplinary care systems to build better quality care.

References

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2. Office of the High Commissioner for Human Rights. FAO. The Right to Adequate Food Fact Sheet 34. <http://www.ohchr.org/Documents/Publications/FactSheet34en.pdf>. Accessed 24 July 2017.
3. Wright ORL, Capra S, Connelly LB. Foodservice satisfaction domains in geriatrics, rehabilitation and aged care. J Nutr Health Aging 2010; 14: 775 – 780
4. Stafrace S, Lilly A. Final report on the Review of the Makk & McLeay Nursing Home. <http://www.sahealth.sa.gov.au/wps/wcm/connect/20a29e0040e4b822868ba73ee9bece4b/Final+Report+%E2%80%93+Makk+%26+McLeay+Nursing+Home.pdf?MOD=AJPERES&CACHEID=20a29e0040e4b822868ba73ee9bece4b>. Accessed 24 July 2017.
5. Nutrition Standards for consumers of inpatient mental health services in NSW 2013. https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0013/201091/ACI-Nutrition-Mental-Health-Inpatients-web-final.pdf Accessed 24 July 2017
6. Abbey KL, Wright ORL, Capra S. Menu planning in residential aged care – The level of choice and quality of planning of meals available to residents. Nutrients 2015; 7: 7580 – 7592

Appendix

Possible prompts to guide service providers and accreditors in quality nutrition systems.

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?