Australian College of Nursing

IMPROVING THE FOOD, NUTRITION AND MEALTIME EXPERIENCE IN AGED CARE

THE AUSTRALIAN COLLEGE OF NURSING (ACN) SUBMISSION TO THE AGED SERVICES INDUSTRY REFERENCE COMMITTEE (ASIRC)

ACN General Comment

The Australian College of Nursing (ACN) believes that caring for frail and vulnerable persons is considered high risk; and food, nutrition and meals for those in aged care is a priority. ACN strongly believes that Personal Care Workers (PCWs) should not have autonomy in making decisions around food; and decisions of this nature must always be led by a highly trained Registered Nurse (RN) or referred to an RN by a PCW.

ACN is of the view that a skilled workforce is required to meet the food and nutritional needs of older people in aged care; particular around identifying any feeding issues and preventing secondary issues that may result. Aged care staff also need to be culturally responsive in order to improve the dining experience of aged care residents, many of whom come from Indigenous or Culturally and Linguistically Diverse (CALD) backgrounds. The Nursing and Midwifery Board of Australia (NMBA) Code of Conduct for Nurses requires a nurse to engage with people as individuals in a culturally safe and respectful way.[1] Culturally safe and respectful practice requires having knowledge of how a nurse's own culture, values, attitudes, assumptions and beliefs influence their interactions with people and families, the community and colleagues.

Overall, ACN believes that steps need to be taken to avoid devaluing and dehumanising the needs of people in care, particularly around food.

ACN Response to Consultation Questions

Q1. What is the single most practical/realistic action we can take in terms of skills to improve the food, nutrition and mealtime experience:

a. For cooking and catering specialist roles?

ACN believes it is essential for mealtime experiences to be directed by a clinician, such as a nurse or a dietician, and then supported or implemented through other workers such as chefs and unregulated health care workers (e.g. personal care workers) under supervision and clear instruction from the clinician.

In ACN's July 2020 submission to the Aged Services Industry Reference Committee (IRC) on the *"Critical workforce and skill needs during the COVID-19 pandemic: a Skill Set targeted at qualified Chefs to move into Residential Aged Care"*, ACN expressed that any training for chefs in aged care needs to be built around competency standards. This would necessitate reviewing the content of vocational education training (VET) qualifications and units for care workers, chefs and kitchen staff to ensure the material developed and delivered is evidence-based and addresses the management of food and nutrition related risks experienced by older people. This includes malnutrition, dysphagia, food allergy and intolerance, therapeutic diets and food safety including infection control.

ACN consulted its members and their feedback on measures that can be taken to improve the food, nutrition and mealtime experience of individuals in aged care is as follows:

[1] The Nursing and Midwifery Board of Australia (NMBA), 2018, *Code of conduct for nurses*, p. 9.

- Enable residents to participate in their own meal preparation as much as possible. Participation can encourage the development of positive attitudes towards food and eating. Food preparation can be done onsite or in locations where residents can experience, smell and interact with the ingredients and staff in the kitchen in a safe way. Residential Aged Care Facilities (RACF) will also need to accommodate individual preferences around specific foods to eat and how these are prepared for eating.
- Creating different dining experiences for residents can create positive attitudes toward mealtime. For example, dining outside the usual meal area once a week.
- Offer "progressive mealtimes" so that residents have the option to choose to eat when they are hungry, rather than according to a timetable.
- Increase the meal budget for each resident per day in order to be able to afford quality ingredients and a nutritious meal.
- Develop a placement exchange so staff can gain experience. This is possible if there is a chef in the RACF. If there is no qualified chef on staff, workers cannot undertake apprenticeships.

b. For other staff groups?

ACN members believe that when it comes to food, nutrition and meals for people in aged care, a skilled workforce (i.e. nurse, doctor, dietician, speech pathologist) is required as there are risks for older people when it comes to eating. For example, a personal care worker (PCW) might not be able to identify swallowing issues which are very common amongst older people and people with dementia. Nurses are highly skilled and have the educational background to be able to identify swallowing issues, also known as dysphagia. This is vital to determining the underlying cause (i.e. is a medical condition such as dementia causing dysphagia) and in responding appropriately to prevent secondary issues such as malnutrition.

Dysphagia commonly occurs in people aged over 80 years due to the physiological ageing process. [2] It is however vital to recognise that identifying swallowing difficulties is a high-level care task, as dysphagia has been linked to prolonged recovery time and can contribute to functional decline, frailty and loss of independence in older people.[3] It is also important to recognise the risk associated with the delivery of meals by PCWs and other unskilled staff to older people receiving care in the community (i.e. home based care). In this setting, the risk of swallowing issues going unnoticed or registered health providers not being alerted of issues in a timely manner, may be profound with deleterious consequences.

There is a growing number of unregulated aged care staff from Culturally and Linguistically Diverse (CALD) backgrounds working in aged care. Aged care providers must ensure their staff meet minimum competency standards on English language skills, both verbal and written. Staff must be able to effectively communicate to ensure a safe and quality mealtime experience for older people in aged care.

[2] Health.Vic, 2020, *Swallowing process and its impact on health*, accessed on 16 September 2020, https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/older-people/nutrition-swallowing/swallowing/swallowing-impacts

[3] Health.Vic, 2020, *Identifying people at risk of swallowing problems*, accessed on 16 September 2020, https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/older-people/nutrition-swallowing/swallowing/swallowing-identifying

ACN also recognises that there are many older individuals entering aged care who themselves are from CALD backgrounds, and for this reason, having bilingual staff can be mutually beneficial to facilitate communication where there may be a language and/or cultural barrier around mealtime experience and preferences. It is important for staff to be culturally sensitive and responsive to the nutritional needs of older people from CALD backgrounds (e.g. certain cultures require halal meat).

Q2. What essential skills are required to improve food, nutrition and mealtime experiences in:

a. residential aged care?

ACN strongly believes that residential aged care needs a skilled workforce who are able to identify or at least provide direct supervision of staff with regards to:

- *Food allergens in older people*
  Food allergy is an important public health issue as it can be severe or even life-threatening and appears to be increasing in prevalence. Food allergy is a growing problem amongst older Australians aged greater than 65 years.[4] In August 2020, ACN provided a submission to the National Allergy Strategy, for the consultation titled, "*All about Allergens for Hospitals: Ward Managers and Nurses Online Training module"*. ACN recommended that the *Ward Managers and Nurses Online Training module* provide information on allergy management for elderly people as the majority of hospital admissions are for people aged 65 years and older.[5] In relation to this, there is also a need for the National Allergy Strategy to be developed specifically for the aged care sector, including residential aged care, community care and in disability services.

- *Cultural sensitivity and responsiveness to Indigenous and CALD people in aged care*
  Food provides more than just nourishment; it creates and preserves a sense of identity for many people. Food can be used as a 'bridge' to connect people to their homeland, culture and family. For these and other reasons, many elderly people want to consume food and drinks in accordance with their cultural traditions. It has been reported that the cultural care needs of some Indigenous residents have been largely ignored due to a lack of information about residents in their care plans, including meal plans, and poor communication processes between leadership and carers.[6] Cultural unawareness amongst staff can contribute to a lack of understanding for the needs of Indigenous and CALD residents.

- *Feeding issues in older people*

[4] Laia-Dias, L, Lozoya-Ibáñez, C, Skypala, I, et.al., 2019, 'Prevalence and risk factors for food allergy in older people: protocol for a systematic review', *BMJ Journals*, Volume 9, Issue 8. https://bmjopen.bmj.com/content/bmjopen/9/8/e029633.full.pdf

[5] Australian Institute of Health and Welfare, 2019, *Admitted patient care 2017–18: Australian hospital statistics*, Canberra, accessed on 16 September 2020, https://www.aihw.gov.au/getmedia/df0abd15-5dd8-4a56-94fa-c9ab68690e18/aihw-hse-225.pdf.aspx?inline=true

[6] Sivertsen, N, Harrington, A & Hamiduzzaman, M, 2019, 'Exploring Aboriginal aged care residents' cultural and spiritual needs in South Australia', *BMC Health Services Research*, Volume 19, Number 477, https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-019-4322-8

Aged care staff should conduct mealtime assessments to be able to observe and evaluate residents' issues in eating. If they see swallowing difficulties, they should refer them to health professionals to have a comprehensive assessment and intervention plan. Mealtime management interventions might be needed to respond to existing swallowing problems or diagnose new ones. It is essential that all staff who play a role in food preparation, delivery and assistance at mealtimes are aware of the risks and signs of dysphagia, and what to do if there is a problem.[7]

b. home care?

Similar to the skills mentioned above, those who are involved in the care of older people in the community setting (within their homes) would need to be able to identify or at least provide direct supervision of staff with regards to food allergens and eating issues; and be culturally responsive to food requirements for Indigenous and CALD peoples.

Some further suggestions for home care are:

- Prepare food in the home rather than deliver pre-heated meals or pre-prepared meals.
- Weekly dine out experiences to change the mealtime experience.[8]
- Provide greater choice around the menu according to individual food preferences.
- Ensure staff are adequately trained and skilled to manage anorexia and other eating issues. This includes knowing when and who to report to, and how to request a nutrition and health professional screening and assessment.
- Professional involvement is needed to assess and develop care plan, instructions and training for personal care workers.

In addition, delivering meals in home care serves as a connection point. Many older people in the community experience loneliness so may seek or expect to discuss other medical issues when their meal is delivered.

- If this is out of scope of practice for unskilled worker, the consumer may find it distressing if they cannot discuss their concerns. On the flip side, if these issues are discussed with an unskilled worker during mealtime, there may be something urgent that needs to be escalated to a registered health care provider but gets missed because the unskilled worker does not have the training to understand the significance of the information given. (i.e. there is risk of "role blurring").
- There are no guarantee that unskilled/unregulated workers will work under the direct supervision of a regulated health care worker, nor that a Registered Nurse (RN) will always be present and/or available in this setting. There is also no guarantee that the worker will be aware of all out of scope activities to know when to refer to an RN or other regulated health care worker. Therefore, it is important that it is vital for aged care providers to employ a skilled workforce.

[7] Victoria Health, 2020, *Responding to swallowing difficulties*, accessed on 16 September 2020, https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/older-people/nutrition-swallowing/swallowing/swallowing-responding

[8] Aged and Community Services Australia (ACSA), 2020, *Nutrition and meal experience in aged care*, accessed on 21 September 2020, https://www.acsa.asn.au/News/Nutrition-and-meal-experience-in-aged-care

Q3. Does meeting the needs of consumers require aged care services to provide:

a. a specialised role(s) providing leadership in the area of food, nutrition and mealtime experience?

Ideally a dietician in conjunction with a Registered Nurse (RN) should provide this leadership role for all consumers and not just those with specific health/feeding issues; as good nutrition improves an individual's overall quality of life and health. Any individual in this specialised role should work directly with management, the head of catering and the chef to ensure that:

- Nutritional requirements are met
- The texture of the food is appropriate and meets each individuals' needs
- Staff are available to assist consumers with meals, especially those with eating difficulties
- There are policies and procedures around infection control prevention and education around food handling

b. in-house nutrition training for care staff and support workers in residential aged care, to keep skills current in malnutrition screening, referral pathways and documentation processes?

Yes. It is better to focus on the prevention of malnutrition, which can be missed, before focusing on malnutrition screening. In-house nutrition training for care staff and support workers should be a regular program. Trainings can take the form of annual staff training, online study, and staff meetings to ensure policies and procedures are in place and are being adhered to.

Residents should be weighed monthly unless otherwise recommended (e.g. Congestive Cardiac Failure and fluid retention), to determine if there has been any weight loss, and to discuss the reason and management options going forward.

Q4. If so, what capacity is there to create these roles? What obstacles are there to providing this focused leadership and the improvement of skills?

ACN members believes a paradigm shift in staffing, models of care and respect for individual needs and choices is required. Resources such as finance, time, access to literature, and leadership must be provided in order to create specialised roles that improve food, nutrition and mealtime experience among aged care residents.

ACN's membership provided the following feedback around obstacles:

- There is no time or funding for educating the whole team.
- There is a lack of suitably qualified leaders in the area of food and nutrition to promote the best mealtime experience for those in aged care.
- Aged care is not being seen as a career pathway for leaders in this field.
- The content in the Certificate III and IV for PCWs is lacking and more infection control prevention and food handling education is required.
- Lack of understanding of the importance of the role of nutrition in aged care.
- A lack of skills around identifying and reporting reduced nutritional intake or weight loss.
- Poor reporting and documentation of nutritional input.
- Greater understanding around person centred care as it applies to nutrition is required.
- Resident dignity and choice in relation to nutritional needs is required.
- Practical assistance for residents with meals and drinks is required.

Q5. What are the skills required for Personal Care Workers (PCWs) in food, nutrition and the dining experience?

a. What level of skills and education is required to support PCWs to understand health care objectives relating to food and nutrition, and how these can be aligned with consumer centric goals?

ACN members consider mealtime as very important to provide the nutrients which are essential to maintaining an elderly person's wellbeing. As their general health deteriorates, older people may need assistance in consuming their meals. There is a checklist that PCWs should follow when assisting aged care residents in the mealtime:

- Is the person sitting upright?
- Are they in reach of their meal?
- Are the eating utensils and cups appropriate?
- Be mindful of how much is being consumed at each mouthful
- Have sips of drinks in between to help with fluid intake
- Try not to talk to other people while feeding a resident/loved one
- Ask the person if they would like a cloths protector
- Make sure tables and trays are set.[9]

ACN supports the use of regulated health care workers such as nurses to care for elderly people in aged care facilities as they have the required skills to achieve health care objectives relating to food and nutrition. The role of a skilled carer is especially important when caring for someone with dementia or cognitive impairment as it may affect their ability to eat and the dining experience of those around them.

While PCWs are a valuable workforce, they do not often have the necessary training or skills to identify and assess for swallowing issues. A higher level of skills is required than what is met in the Certificate III and IV training for PCWs. ACN members expressed concern that in reality, staffing levels and rostering practices in aged care means that each PCW has numerous residents to assist with their meals.

Instead, ACN members recommend that at a minimum an Enrolled Nurse (EN), who works under the direct supervision of an RN, be afforded the opportunity to upskill and undertake increased responsibilities around food/nutrition/mealtime for older people. This includes how to prompt and assist a resident to eat/drink, ensuring proper consistency of food and drink, what to do if suitable food is not provided, what to report, how to record consumer wishes, and ensure that they are included in care plan.

b. What's realistic in terms of the skills and capabilities of a PCW if the current context of the role is that of an entry-level, minimum wage worker with an entry-level qualification?

ACN members suggest that an entry level PCW should only be assisting existing skilled workers and be supervised at all times. They should not be left on their own with the entire complexity of food

[9] Talking Aged Care, 2020, *Dignity in the Dining Room*, accessed on 16 September 2020, https://www.agedcareguide.com.au/talking-aged-care/dignity-in-the-dining-room

preparation, delivery, feeding and cleaning. Supportive mentoring can enhance a PCW's skills in order to be able to provide personal care and assistance with food and mealtime.

PCWs cannot be expected to assess and plan care in the way that RNs do, but their voice must be included in RNs assessment and planning as PCWs are part of the care team. They can be expected to report changes in resident, requests from family and contribute to improved care.

Q6. Looking at innovative models of care, such as Homemaker, which involves the PCW assisting residents with activities such as meal preparation, what skills are required to undertake this role?

ACN members reinforce that PCWs must be supervised and work under the direction of a RN. However, PCWs could assist residents around meal preparation, cooking, safe food handling, ensuring cleanliness of food prepping areas where appropriate. Communication skills, proficiency in English, being supportive and a person centred approach would be necessary to enable resident participation and to effectively engage with residents who have dementia or other cognitive or neurological impairment.

Q7. What level of supervision would be required for the PCW?

PCWs require a RN or a specialist degree qualified staff to supervise them. In the home care setting where a PCW works alone, unannounced supervision and visits from a manager can be useful to check the continuation of their care quality. PCWs should have periods of working in a team in order to assess their skills. In addition, annual competencies after full education sessions have been completed is also recommended.

Q8. How much autonomy would the PCW have to make decisions about meals, nutrition and the dining experience?

ACN members are of the view that PCWs should not have autonomy to make decisions about meals, nutrition and dining experience. Instead, they should work under the direction of an RN, or appropriate Allied Health Professional and be responsive to residents' requirements including seeking help where appropriate. Clear guidelines, procedures and care plans for each resident should be made clear and routinely checked for changes. PCWs should understand what decisions they can make in what circumstances, and what needs reporting/referral to supervisor (RN).

Q9. What level of training in meal preparation and nutrition would be necessary?

ACN members suggest that meal preparation and nutrition should be directed by a nurse or a dietician. Then they can allocate some tasks to other staff for implementation such as chefs and PCWs.

As mentioned previously, PCWs can help with cleaning food preparation areas; however if more responsibilities are to be given to PCWs there should be:

- A component on food and nutrition in the Certificate III and IV training for PCWs, which covers infection control prevention and food handling.
- Evidence-based training material should be developed for PCWs to understand the relationship between meal preparation and food/nutrition related risks experienced by older people. This includes malnutrition, dysphagia, food allergy and intolerance, therapeutic diets and food safety including infection control.

Q10. What skills are required to identify the reasons why a resident may be suffering appetite loss?

Assessment of why a person suffers appetite loss involves a high level of clinical observation and assessments. This requires the professional input of the entire health team, including GPs, RNs, ENs, dieticians and food services team. If there is a focus on prevention of malnutrition, then appetite loss should be routinely assessed and changes noted. The entire team will need to assess the type of food that residents like or dislike, their appetite, pain experiences, past and present health medical and surgical history. For PCWs, they must report any issues identified to the RN in charge.

It is important to note that dementia patients are at increased risk of malnutrition for reasons such as forgetting when to eat and how to eat and often be unable to articulate their concerns. A trained health professional understands these appetite changes are common in people suffering from dementia and can take the necessary steps to prevent malnutrition.

Q11. What are the skills required for Enrolled Nurses in food, nutrition and the dining experience?

ENs work in the routine assessment on food, nutrition and dining. ENs are under the supervision of the RN who deals with more complex issues relating to food, nutrition and dining such as swallowing difficulties, uncontrolled diabetes and food intolerances. ENs would require further skills on dementia care, dentition, past and present health medical and surgical history, social intelligence (i.e. environment, resident interactions and staff behaviour), skilled hand feeding and communication with residents.

Q12. What are the skills required for Registered Nurses in food, nutrition and the dining experience?

According to the Code of conducts for nurses by the Nursing and Midwifery Board of Australia (NMBA), nurses provide safe, person-centred, evidence-based practice for the health and wellbeing of people and, in partnership with the person, promote shared decision-making and care delivery between the person, nominated partners, family, friends and health professionals.[10] This requires RNs to professionally care for the health and wellbeing of aged care residents including through the provision of appropriate food, nutrition and dining experience to the residents.

The New Quality Aged Care Standards introduced from 1 July 2019 acknowledge the need for PCWs to be available to support aged care residents to eat and drink. [11] However, they should recognise the lead role of a RN in mealtime management, although sometimes a RN who cares for over 50 residents will struggle to provide the level of oversight required.[12]

As explained earlier, the RN coordinates the team in relation to specific and more complex food and nutrition needs, such as day to day swallowing assessment in conjunction with the speech therapist and or dietician. The RN also coordinates the food and nutrition requirements for diabetics,

[10] Nursing and Midwifery Board of Australia (NMBA), 2018, *Code of conduct for nurses*, p.4.
[11] Aged Care Quality and Safety Commission, 2019, *Aged Care Quality Standards 2018*, accessed on 21 September 2020,
https://www.agedcarequality.gov.au/
[12] NSW Nurses and Midwives' Association, 2019, 'Food for Thought Nutrition & Hydration in Residential Aged Care', *Report on the NSWNMA 2019 Aged Care Survey: Part Three*, Professional Issues 11, accessed on 21 September 2020,
https://www.nswnma.asn.au/wp-content/uploads/2019/07/Food-for-Thought-FINAL.pdf

especially those on insulin or experiencing instability in their blood sugar control. For these reasons, RNs would require higher clinical education, exceptional skill in clinical observation and assessment, knowledge of healthy dietary requirements, a sound understanding of the roles of ENs and PCWs who are under their supervision, directive skills, staff management skills (including work schedules, staffing, resources and education/training), an ability to communicate effectively with clients and family and person-centred skills. In summary, RNs should have excellent leadership, interpersonal, assessment, care planning, review and monitoring, infection control and documentation skills.

Q13. What are the skills required for cooks and chefs in food, nutrition and the dining experience?

ACN members believes that a dietician who has the expertise in food, nutrition and health should plan and organise the meal at aged care facilities in consultation with the resident. Cooks and chefs should only be assisting in the operational level and follow the plan and guidance of the dietician and RN. Cooks and chefs need to understand that food experience is deeply important and cultural to those in aged care as meals are a primary source of nutrients to maintain resident health.

In addition, cooks and chefs must be adaptable with a basic knowledge of food safety to meet the individual needs of the person when delivering person-centred care (texture of food, type of food, allergy free). Further, they will require skills in food preparation, promoting positive eating experiences, offering healthy and appetising menus, accommodating ethnic/cultural needs. They will also need to be active listeners, with an ability to elicit feedback from residents and family; and work as part of a team with other care staff to ensure the timely service of food.

Providing culturally safe aged care services includes ensuring that residential facilities serve Indigenous traditional foods so people can maintain their connection to country and culture. Some residents experience cultural and spiritual loss associated with reduced hunting of traditional foods, which is an important factor in the health and wellbeing of Indigenous people.[13] In some aged care facilities, elderly Indigenous residents rely on family members to bring them freshly caught fish as nursing homes fail to accommodate their cultural needs.[14]

Preferences for culturally diverse food can impact on food choice and also nutritional status of residents. Unfamiliar menu items and dissatisfaction with the menu often leads to reduced oral intake. Understanding the food preferences of CALD residents is essential to designing and delivering food services to meet their needs. If these preferences are not accommodated there may be significant ramifications for long-term health and welfare. It is the responsibility of the RACF to have systems in place to accommodate the dietary preferences of CALD residents as best as possible. It is important to consult with the residents and family members for information and suggestions to guide the process. This is also to prevent unnecessary dietary restriction.[15]

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[13] Dietitians Australia, 2020, *Health and Wellbeing of Aboriginal and Torres Strait Islander people*, accessed on 21 September 2020, https://dietitiansaustralia.org.au/smart-eating-for-you/smart-eating-fast-facts/healthy-eating/health-and-wellbeing-of-aboriginal-and-torres-strait-islander-people/

[14] Martin, L, 2019, 'No fresh fish and no respite care: the challenges facing Indigenous aged care', *The Guardian*, accessed on 21 September 2020, https://www.theguardian.com/australia-news/2019/jun/18/no-fresh-fish-and-no-respite-care-the-challenges-facing-indigenous-aged-care

[15] Leading Nutrition, 2015, 'Meeting food needs of CALD residents in aged care', *Nutrition Matters*, accessed on 21 September 2020,

It is therefore important that all residents in aged care are provided with nutrition services that meet their specific needs. Cooks and chefs will need to have skills around menu modification plans to help residents maintain their traditional eating patterns in accordance with their religious or cultural beliefs. This will help to improve the enjoyment of food, nutritional intake and quality of life for residents of CALD or Indigenous backgrounds. An Accredited Practising Dietitian (APD) may need to work with cooks and chefs; as well as Indigenous and CALD health workers to meet these needs.

Q14. Is there a new role that could address the food, nutrition and mealtime experience, including presentation, taste and service?

a. Is there a need for specialised skill sets or microcredentials to build on existing expertise?

ACN members recommend regular training and skill development programs for existing staff. All team members involved in the meal preparation and delivery can be trained to learn about the importance of food, nutrition and how to improve meal experience. Training should emphasise the health conditions of residents, consideration of cultural preference, improvements of meal preparation and delivery and appropriate change practices.

b. What would be the role of customer service and hospitality skills? Would these be additional skills required of a PCW, or what other parts of the aged services workforce?

ACN members believe that customer service and hospitality skills may benefit PCWs as well as all other staff particularly around food management. mem

In relation to dining experience, customer service and hospitality skills such talking and interpersonal skills would be beneficial for PCWs – particularly when speaking with residents and their families about food preferences or requirements. Families can often feel powerless to make change related to the food and dining experience for their loved ones in care. However, any communication or input from family via the PCW should be reported to the RN in charge.

c. What is the role of allied health professionals with respect to this?

ACN members recommend menus are regularly reviewed by a dietician. Other allied health professionals should focus on supervision and monitoring for signs and symptoms of eating problems such as weight loss and anorexia.

Dieticians and speech therapists are usually the two health professionals who play one of the most important roles in this area. They should be used as a referral source for resident's that require assessment.

Q15. What skills are required to support individuals if they refuse to eat or want to eat something that is not recommended for them (such as a diabetic drinking a sugary drink)?

a. What level of autonomy should the PCW have in making these decisions?

ACN members believe that PCWs should not have autonomy in making these decisions. Decisions of this nature must always be referred to the RN, and dietician, as PCWs do not have the education or competency to make these types of decisions.

https://www.leadingnutrition.com.au/wp-content/uploads/2015/02/Nutrition-Matters-Feb-2015.pdf

Nevertheless, RACFs have a particular principle called “dignity of risk” that respects individuals’ decision. Dignity of risk is the principle of allowing an individual the dignity afforded by risk taking, with subsequent enhancement of personal growth and quality of life.[16] It clearly states that the person is entitled to choose an activity or food that may be risky for them as an autonomous individual (or their representative if they require one). The organisation needs to document the desire for things that are considered "risky", such as sandwiches for people who have a swallowing difficulty, but they refuse to eat mashed food.

b. What skills are required for PCWs to be able to make decisions and provide support to residents that assist preservation of personal dignity and optimise healthy eating?

As mentioned earlier, ACN members recommend that PCWs should not have the authority to make decisions in this area but play a support role. In house training and mentoring in this area would be appropriate.

Q16. What skills are required to: a. plan and document the nutrition care for each person in advanced care plans, per the Nutrition and Hydration Guidelines for Hospitals and the National Safety and Quality Health Service (NSQHS) Standards?

Aged care facilities are not regulated by NSQHS Standards as they are not health service providers. They are regulated by the Aged Care Quality and Safety Commission under Standard 3, ‘Personal care and clinical care’, and the planning Standard 2, ‘Ongoing assessment and planning with consumers’.[17,18]

Planning and documenting the nutrition care for each person require skills in nutritional assessment, such as those possessed by a dietician and RN. PCWs should not plan the meal but they can learn the skill to document the food and drink consumption of residents.

b. accommodate food/meal preferences and choices for people at the end of life in consultation with individuals and their families?

ACN members consider this role is suitable for a RN or an EN. In home care, PCWs can be expected to take note of choices, report them to supervisor to incorporate in care plan as appropriate and communicate changes to family. Good communication skills are always required. Skills required for this purpose are high level assessment skills involving clinical reasoning, critical thinking, documentation, care plan review and evaluation, knowledge of palliation, negotiation and communication skills, and an ability to identify the end of life pathway.

Q17. Who should be responsible for this planning, documenting and accommodating?

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[16] Woolford, M, de Lacy-Vawdon, C, Bugeja, L, et al., 2019, ‘Applying dignity of risk principles to improve quality of life for vulnerable persons’, *Geriatric Psychiatry*, Volume 35, Issue 1, pp. 122-130.

[17] Aged Care Quality and Safety Commission, 2020, *Personal care and clinical care*, accessed on 21 September 2020, https://www.agedcarequality.gov.au/sites/default/files/media/Guidance%20and%20resources_Standard%203.pdf

[18] Aged Care Quality and Safety Commission, 2020, *Ongoing assessment and planning with consumers*, accessed on 21 September 2020, https://www.agedcarequality.gov.au/sites/default/files/media/Guidance%20and%20resources_Standard%202.pdf

RNs should be responsible for planning, documenting and accommodating. RNs are also to document the care plan and make it available to all staff to follow. ENs and PCWs can assist in documenting what is actually eaten, or any liquids consumed; and may have discussion with the residents' family, however any communication must be communicated with the RN.

Q18. If the Aged Care Quality and Safety Commission allowed specific online training modules developed for cooks and chefs working in residential aged care, would industry pay the additional annual licence fee and the associated costs of delivering content? Would there be any parameters around what they would be prepared to pay?

ACN members suggest that organisations pay for the initial education training modules, and then the cooks/chef undergo continuing professional development (CPD) throughout the year.