NATIONAL CONGRESS
ON FOOD, NUTRITION
AND THE DINING EXPERIENCE
IN AGED CARE

National Congress Findings Report

Food, nutrition & the dining experience in aged care

9th March 2021

Contents

Executive Summary

The Department of Health teamed up with the Maggie Beer Foundation to conduct a two-day National Congress re-imagining the future of food, nutrition and the dining experience in aged care in Australia. 130 leading aged care subject matter experts attended and contributed actionable steps that the Department could consider to transform aged care.

National Congress background and overview

The National Congress on food, nutrition and the dining experience in aged care was held on 18 February 2021 as a hybrid event due to COVID 19 restrictions. Shortly thereafter, the Royal Commission into Aged Care Quality and Safety's Final Report was handed down on 26 February and made public on the 1 March 2021.

The Congress took place at the International Convention Centre in Sydney and was available to virtual participants through a dedicated online platform. It was followed by the Congress Workshop, attended mostly by members of the Congress Working Group, which helped in the design of the pre-reading material and the Congress itself.

This initiative by the Department of Health and the Maggie Beer Foundation was acknowledged by the Minister and participants. The breadth of narrative at the Congress was appreciated and there was general encouragement to continue to share expertise and to collaborate in the interests of those in aged care.

The Congress addressed nine key topic areas identified by the Working Group:

- The importance of food
- Best practice – Australia and around the world
- Consumer choice and dignity
- Nutrition
- Oral health, swallowing and hydration
- Food production and presentation
- Menu planning and innovation
- Dining experience
- Staff, skills and training

Findings and actions

This report provides the findings and actions identified under each of the topic areas. Over the course of the Congress, 56 findings emerged with 139 possible actions that could potentially be taken to address some of the current pain-points with aged care.

In addition to this report additional outputs from the Congress process have been provided to the Department of Health:

- Landscape survey of current food practices
- Literature Review
- Collation of manuals and reports
- Presentations from keynote speakers Edwig Goossens, Dr Heather Keller, Dr Cherie Hugo and Barry McKibben
- 27 Submissions from organisations and experts

Across the two days of the Congress and the workshop several themes emerged. These themes are provided to the Department of Health to assist with their examination of the pre-Congress documentation and the Congress outputs.

1. Food, nutrition and the dining experience is an **urgent issue**
2. Australia is not the only country with these issues and would benefit from increased international awareness and collaboration
3. There is **variability** in the quality of meal experiences with some homes demonstrating successful initiatives to improve practices, but many homes exhibiting poor practices. A clear direction and commitment by management has been required to implement effective change.
4. There is a lack of **transparency and accountability** in the delivery of food, nutrition and the dining experience. Best practice screening and reporting on malnutrition, Quality of Life and food experiences will improve informed choice for residents and their families.
5. The **workforce** engaged in the planning, preparation and serving of food is in many instances not adequately rewarded and lacking in the skills necessary to fulfill their roles to minimum standards. Elevation of the roles of chefs and the introduction of training programs for all those involved in food handling, serving and preparation are required to improve the quality of the workforce.
6. **Health and allied health** professionals including GPs, dietitians, speech pathologists, occupational therapists, dentists and dental hygienists, mental health workers, podiatrists, physiotherapists and others are not adequately available to residents. The creation of multidisciplinary teams was well supported by the Congress

(continued)

7. **Oral health** of residents coming into aged care is not always good and increased dental services and attention to oral health by care workers within aged care will alleviate many eating problems
8. Mechanisms to ensure collaboration between management, health professionals, nursing staff, cooks and chefs and **Resident Foodie Groups** will result in foods that better suit cultural and residential diversity and provide greater choice.
9. The joy of food can be increased by **Infrastructure changes**. One successful approach has been to remove certain institutional food preparation practices and large dining halls and replace them with accessible home styled kitchenettes where food can be cooked and finished attractively, residents can participate, and aromas and flavours of fresh food drive appetite. The small household model of accommodation facilitated this approach.

Frequency key

Attendees came up with tangible actions that would make an impact on the future aged care experience and the frequency of similar ideas was recorded across the conference to measure consensus across the Congress.

Workshop capture

● = 0–5 ● = 6–10 ● = +10

Other capture

● = Gathered from panel discussion and presentations

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THE AUSTRALIAN GOVERNMENT
DEPARTMENT OF HEALTH
IN PARTNERSHIP WITH THE
MAGGIE BEER FOUNDATION

The importance of food

The importance of food

For too long food has not been seen as a priority in Aged Care. It has often been an afterthought, bundled with other operational services such as laundry, cleaning and gardens. We heard that in Europe the 'Treaty of Rome 2017' agreed that all older persons should have access to tasty, healthy and safe food corresponding to the cultural traditions they belong to.

> "While adequate food and nutrition is essential to sustain life, health and reasonable standard of living, food is also a fundamental part of how we engage with our family, our friends and loved ones, how we express our ethnicity, our religious beliefs, our culture and our language. Great food served well has the power to bring moments of joy to each day, even in the face of advanced dementia.

FINDING 01

Whole of organisation reviews of food and resident engagement with a focus of individualising programs

Possible actions:

- Facilitate processes where a lot of small, simple changes at the grassroot level to meet individual food needs add up to major reform

FINDING 02

New residents have different expectations from residents of 10 years ago – less answerable to a protective, disciplinary culture

Possible actions:

- Challenge the old beliefs in aged care with what is desirable for today's residents.
- Remove the beliefs that no resident can cook, that no residents have a useful contribution to make and create mechanisms for engagement such as foodies groups.

FINDING 03

If infrastructure barriers are removed residents have more freedoms. It doesn't need to be overcomplicated. It just needs to be a familiar homestyle kitchen.

Possible actions:

- Promote ongoing best practice programs such as the removal of serveries behind the wall and open it up into home style kitchens.

FINDING 04

Residents eat more when they can smell what is being cooked

Possible actions:

- Utilise homestyle kitchens to cook more of the time. Bake cookies, cook toast, stove top frying all of which create cooking aromas. Production kitchens can still be used in parallel to produce the bulk of the meals

FINDING 05

Residential aged care is a home and needs to enable residents to have the freedoms that they are used to in their homes.

Possible actions:

- Create the mindset amongst management and all staff that this is really the home of the residents, they live there but the staff leave to go home.
- Encourage families to come in and cook and eat with the residents.

FINDING 06

Many of our residents and our staff come from different cultural backgrounds. Rather than a problem this can be a celebration.

Possible actions:

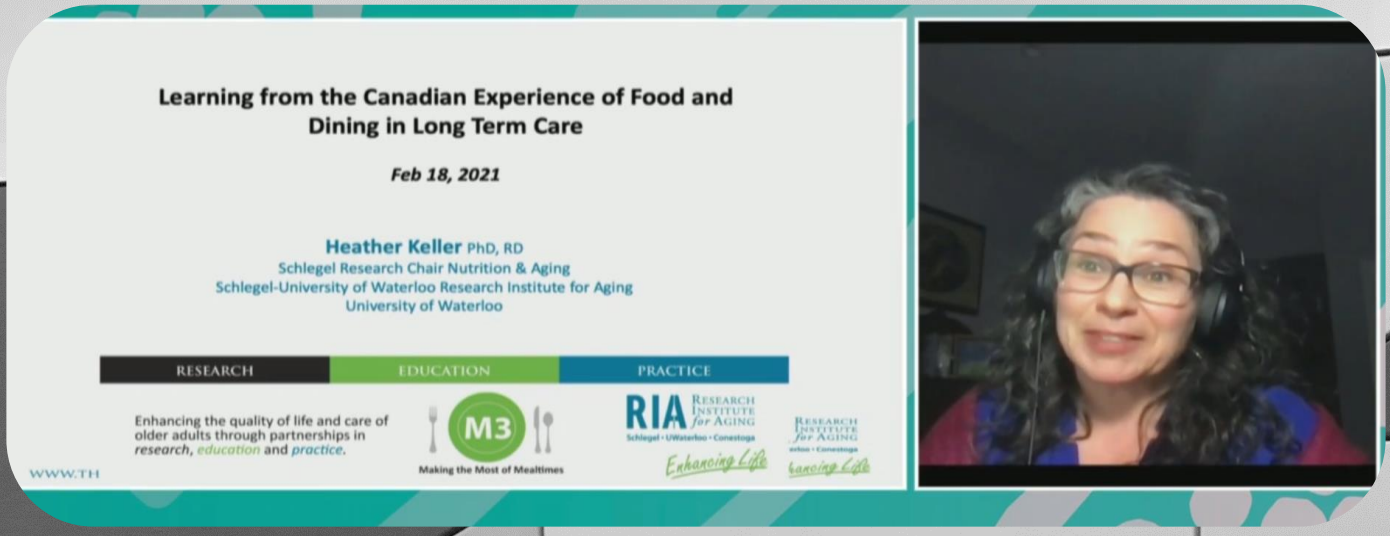
- Get to know the residents and the staff and their food choices, then find ways to include the breadth of preferences.
- Important that the "calendar of cultural events" does not become tokenistic. Far better to have families and communities and residents involved. The inclusion of language and food is collaborative, not tokenistic, and more enjoyable

FINDING 07

We need to understand what impediments have existed in the past, particularly concerns about risk and liability

Possible actions:

- Explore how to alleviate the risk and liability concerns and how to incentivise respecting legitimate choices of those in aged care.



Best practice – Australia and around the world

Best practice – Australia and around the world

An important element of the Congress process was to present and review examples of best practice. The examples provided were identified by the Working Group, by the Maggie Beer Foundation or through the Landscape Survey. Final selection for those formally presented to the Congress was validated through the Department of Health. Additional examples are available in the submissions provided to the Department.

The examples provided enabled participants in the Congress to compare and contrast the practices that they are familiar with in Australia. While each example is of high worth it is understood that there may be other examples of best practice not identified for this Congress.

The presentations have been provided to the Department of Health. Below are abstracts of the 4 presentations.

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01 ***A European integrated approach to nutritional frailty*** **presented by Edwig Goossens from the Centre for Gastrology and Primary Food Care**

The key learning from this presentation was that the EU had formed an action group in 2017 to find innovative solutions to critical issues. The action group comprised stakeholders ranging from academia to public authorities, large industry and SMEs, health and care organisations, investors and innovators, end users and patients' associations. They cover the local, regional, national and European levels. The vision created by the action group led by Edwig is:

> *All EU citizens, especially the growing number of older citizens in hospitals, care homes and homecare and those living with chronic conditions, must have the right to adequate and sufficient tasty, healthy and safe food, corresponding to the cultural traditions they belong to, despite the taste disability they possess and which ensure that they remain independent and active in society, can receive coordinated foodcare and enjoy living longer at home.*
>
> *This journey of foodcare transformation requires modernisation and digitalisation of culinary systems implemented by trained and skilled chefs in healthcare, on the basis of gastrological innovations, gastrologic sciences and cost-effective criteria that will deliver a more targeted, personalised, effective and efficient foodservice, based on the needs and expectations of the senior EU citizens.*

This vision is based on the 2 pyramid model [a Pan-European food and nutritional approach that is nested in the European Innovation Partnership for Active and Healthy Aging (EIP-AHA)]. This model has been developed by members of the scientific board of the Center for Gastrology (Belgium), in collaboration with members of the EIP-AHA Food & Nutrition Action Group.

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02 *Learning from the Canadian Experience of Food and Dining in Long Term Care* by Dr Heather Keller, Chair Nutrition & Aging University of Waterloo

The key learning from this presentation was that a large-scale research program in Canada revealed many factors in common with Australia i.e.

- Poor food intake is endemic in long term care
- Impacts quality of life and health
- Resident, staff, home and province level factors impact food intake
- Complex relationships
- Key areas to improve food intake are eating challenges, quality of food and mealtime experience
- Training staff on how to provide enough assistance, when to provide but not provide too much assistance
- Dining rooms need to improve in terms of physical spaces
- Use CHOICE+ Dining Room Checklists as a starting point
- Mealtime practices need to improve
- Use CHOICE+ Mealtime Practices Checklists, modules and other resources
- Nutrient density needs to improve
- Use the DRI to plan menus, provide sufficient funding, enhance food products with nutrient dense ingredients, create standardized recipes

The outcome of the research was the development of a collaborative action plan called CHOICE which is " A relationship-centred program to improve the mealtime experience in long-term care"

03 *From problems to solutions* presented by Dr Cherie Hugo, Lantern project

The key learning from this presentation was that malnutrition in Aged care in Australia is estimated to cost governments approximately $9 billion per annum and to increase care costs by a factor of 2 to 3. Some of the comments include:

- Food can make or break a resident's day
- 50% of residents are malnourished and most of these cases are preventable
- The problem requires a multi-disciplinary approach

(continued)

- The Lantern approach is a set of evidence-based guidelines
- Epicure is a 5 star diagnostic tool
- Explorer is a consumer voice analysis tool
- The top food first program

We have enough evidence now

Next steps recommended are:

- Support longstanding community of practice
- Mandate providers to have a robust measurement and continuous improvement process
- Improve technology to strengthen the consumer voice
- Support evidence based food first programs to actively target malnutrition and improve quality of life

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04 *Meals matter program at Anglican Care* by Barry McKibbin

The key learning from this presentation is that we should forget the notion of Aged Care food or food for Aged Care and replace it with one of providing a hotel or resort style experience. By taking a proactive approach to both the food and the service it would initialise a culture change within the organisation.

Previously food was thought of in terms of complaints and compliance. Food and the hospitality of service was an addition or an afterthought that came up after the provision of care. The Meals Matter program was created to provide quality meals for our customers. This program is based upon standards

Our Residents dining experience will align with the Aged Care quality standards and include;

- ✓ *Safe & comfortable (5) - welcoming arrival and relaxed atmosphere*
- ✓ *Dignity & respect (1) - personally greeted on arrival and escorted to the table*
- ✓ *Informed & choice (2) - advised of the daily menu choices and beverages available*

(continued)

- ✓ *Service & support (4) - dining service with meal orders taken to order and buffet offerings*
- ✓ *Quality care & services (7) - attentive and unobtrusive service, in correct order and not rushed*
- ✓ *Encouraged & supported (6) - asked for feedback and understood, consulted regarding menu*

Our Meals Matter project is a reinvigoration of the entire dining experience and a change in the culture in the delivery our food services across the organisation.

Making sure food is good in terms of look and taste, presented and served in a way that is more restaurant style than institutional, and the meal the residents enjoy is more a bistro style than a hospital food on a plate

Capital has been invested to align back of house kitchens and to create finishing kitchens adjacent to dining rooms. Workforce roles were restructured. The results of Meals Matter demonstrated major benefits for residents and staff and reduced reactive costs.

The focus is on having the food consumed and helping residents enjoy their meals.

Consumer choice and dignity

Consumer choice and dignity

People entering aged care often lose the choice in what, where and when to eat. There are competing tensions between managing risks and respecting the preferences of residents. Congress attendees agreed more often than not the scales are tipped to the risk averse with little exploration of what risk mitigating opportunities are possible, denying residents true dignity in choice.

> *"* We need to make sure we don't create a society which transfers the risk of someone exercising their choice onto the person helping them do so.

FINDING 08

Risk adversity often prevents residents from making their own choices when it comes to their dietary choices. (e.g. restrictions on foods that might cause choking hazards)

Possible actions:

- Enable the formation of a multi-disciplinary team to produce a food risk management framework for use in aged care
- Allow the facility to decrease their liability by educating the resident (and family) and giving them a choice to make their own decisions through informed consent
- Highlight evidence based and success stories
- Find innovative recipes and cooking techniques to provide additional resident choices

FINDING 09

Many residents find personal value in helping to prepare food, but lack of resources and risk aversion prevents some care providers from accommodating residents in the kitchen.

Possible actions:

- Update policies to explicitly allow for residents to engage in food preparation activities to lower risk aversion from facilities
- Create purposeful resident and chef engagements through increased chef hours and funding
- Create practical and flexible standards/training to allow residents to participate in safe food preparation
- Update policy to make it easier for facilities to grow, prepare, and compost their own foods at the facility
- Provide or upgrade finishing kitchen to enable a level of resident participation
- Provide case studies on successful resident cooking programs that allow residents to cook for themselves and serve to other residents in the facility.

FINDING 10

Many facilities are unable to improve because they lack a formal process to evaluate their performance in the eyes of the residents.

Possible actions:

- Create a clear expectation for quality 360 feedback along with a framework for feedback and collection.
- Provide resident feedback tools such as 'Foodie Groups', surveys, focus meetings and quality of life indicators. Be transparent with the results.
- Provide incentives for those who act upon the provided feedback tools and improve the customer experience for their residents
- Require oral health, dietitians and speech pathologists to observe risks or existing risk mitigation strategies that could be leveraged while eating

FINDING 11

Residents want a personalised level of care, but often staff work in silos and lack a cohesive approach to care

Possible actions:

- Create guides and incentivise person-centred and proactive model of care which involves holistic assessments
- Obtain and distribute access to a database that all care staff can access that can monitor and track information on each resident including history, preferences, beliefs and behaviours in order to get a single view of the resident
- Create best practice guides to match staff members with individual residents to develop personal connections

FINDING 12

Complying with food safety standards can make it challenging to provide consumer choice and dignity

Possible actions:

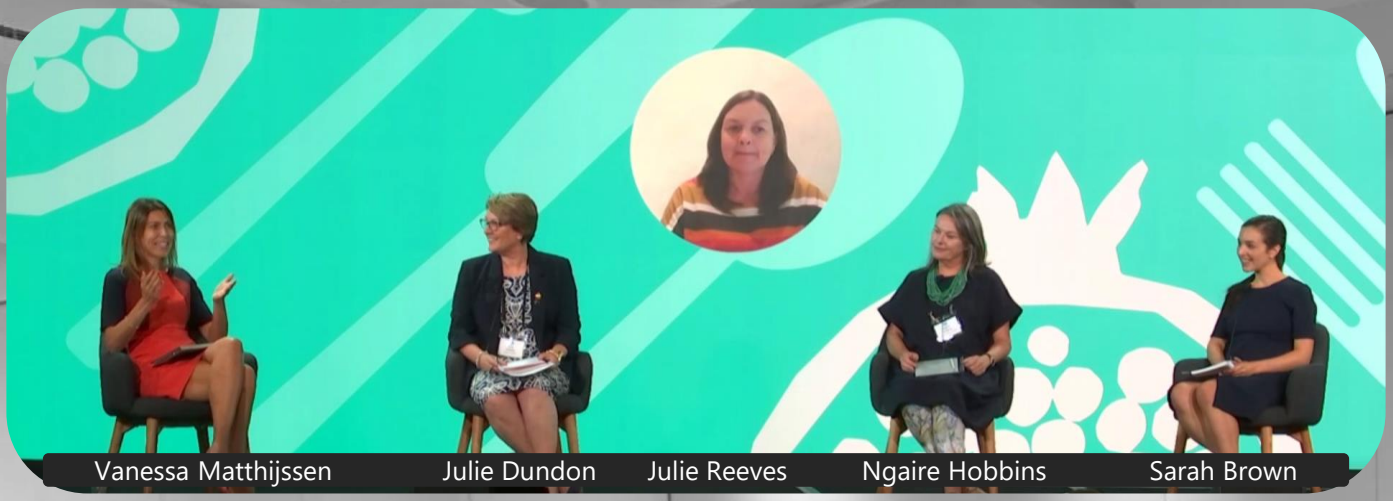
- Make information available on how facilities successfully manage to comply with safety requirements and let residents exercise choice
- Initiate engagement between ACQSC and FSANZ to explore easier ways of providing residents with safe food of their choosing
- Review the regulatory requirements from all levels of Government

FINDING 13

Some decisions are made by organisations with a defensive posture in mind. They don't want to be punished or held liable for an error in satisfying a resident want.

Possible actions:

- Need to start with understanding of what the resident wants and then evaluating if the need can be satisfied
- Consider possible law reform to support resident choice


Vanessa Matthijssen
Julie Dundon
Julie Reeves
Ngaire Hobbins
Sarah Brown

Nutrition

Nutrition

The nutrition needs of over 65s are different from those of younger adults. This is not stated clearly in any official Australian documentation and means that there is no reference material to point to when assessing low-protein home-delivered meals or residential aged care meals. The current mandatory monthly weight checks in residential aged care are not triggering malnutrition screening in most aged care homes. When dietitians are called in, often they are only allocated time to address the clinical needs of specific residents, and are not given time to investigate kitchen and dining practices. Malnutrition screening is done in an hoc way or at times not done at all. Inaccurate required measures like weight loss leads aged care to approach nutrition planning as task to complete rather than truly investigating overall health. Dietitians also lack the freedom to observe what the eating experience is like to explore how this affects nutrition, leading to recommendations which tackle symptoms rather than addressing the cause.

> “ Weight loss and malnutrition are not natural parts of aging. It is vital that we take action to tackle this costly issue.

FINDING 14

Aged care residents' dietary requirements change with age, but there aren't national nutritional guidelines for this age group.

Possible actions:

- Create dietary guidelines for 65 or 70+ that focuses on nutrients over serving sizes and provide support to meet guidelines
- Consider whether there is a way of publicizing the need for protein in 65+ adults as an interim measure while the dietary guidelines are being developed

FINDING 15

Facilities want to improve their resident’s nutrition, but the cost perception of needing to continually improve outweighs the business benefit, blocking action.

Possible actions:

- Implement policy to require all residential aged care facilities to have a Food, Nutrition and Dining Strategy and action plan that includes dietitian contribution
- Implement a policy that would require a minimum budget be proportionately allocated to food in accordance with nutrition guidelines
- Provide financial incentives for increasing full time employment beyond clinical workers
- Create an incentivised quality standards benchmark with clear guidance on how to meet quality standards
- Build in best practice examples and demonstrations into the interpretation of the standards
- Procure access to IT systems to run food programs for qualifying aged care facilities that lack the funds

FINDING 16

Dietitians Australia position "Weight loss and malnutrition are not natural parts of aging. It is vital that we take action to tackle this costly issue. Regular screening will help stop malnutrition in its tracks and prompt aged care homes to address the issues which are contributing to malnutrition."

Possible actions:

- Screening should be undertaken on entry and then at 3 monthly intervals
- Results of 3 monthly re-screens to replace the unintended weight loss indicator
- Residents at risk are to be referred to a registered dietitian
- A nutrition care policy is to be implemented in all homes

FINDING 17

Facilities want to improve health outcomes, but there currently isn't a baseline to track against

Possible actions:

- Use the weight QI information to track progress over time
- Create nutrition guidelines including which food meets nutritional needs
- Include a nutrition component to the initial care recipient assessment and care plan
- Use the regular weight checks required for the QI program to trigger malnutrition screening or referral to a dietitian
- Malnutrition screening, including the malnutrition screening component of the pressure injury assessment tool, should result in a referral to a dietitian if the patient is determined to be at risk of malnutrition
- Oral health screening, nutrition screening and possibly other types of screening should be conducted together

FINDING 18

There is a lack of training in malnutrition screening

Possible actions:

- All aged care staff are to receive annual training on how to identify and manage those who are truly at nutritional risk using a standardised process with a validated malnutrition screening tool

FINDING 19

There is a lack of education on food and nutrition for older people before entering aged care

Possible actions:

- Invest in food and nutrition education for older Australians in the general community

FINDING 20

Dietitians can provide unique insights in that their professional advice is not just for the individual resident, but also relates to kitchen staff, menu design, care staff and others in facility

Possible actions:

- Develop incentives for facilities to engage dietitians to provide advice on the whole food environment, not just care for individual residents

FINDING 21

There is little educational material for consumers in the home or for residential facilities about nutrition in the elderly

Possible actions:

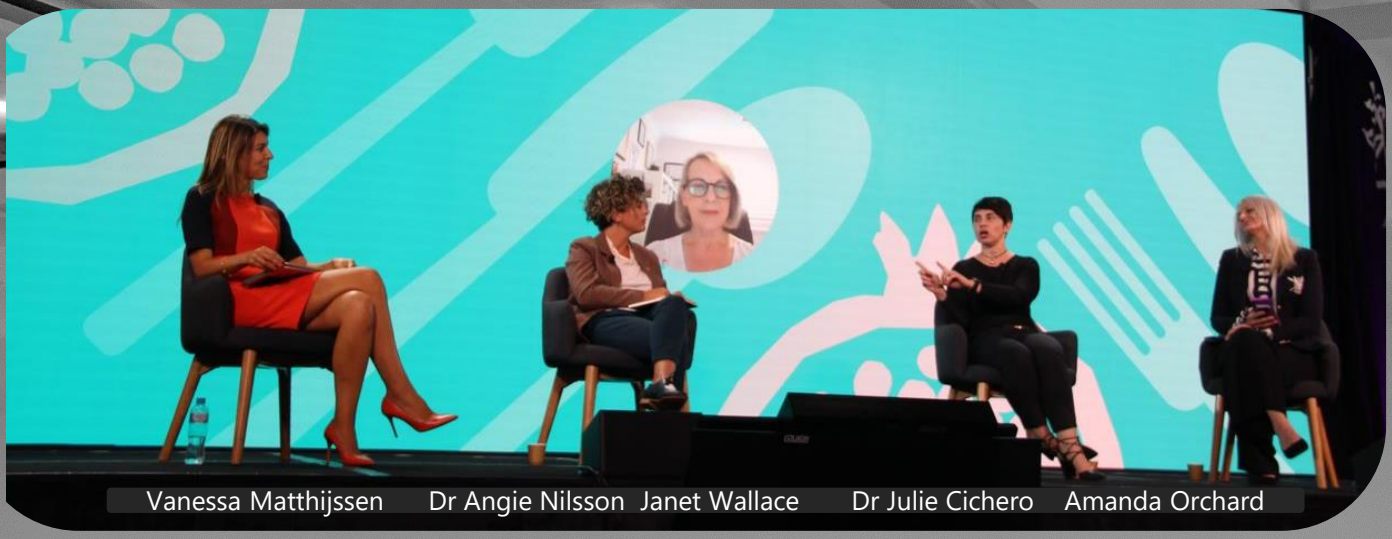
- ACSQC could develop specific education or best practice guidelines for nutrition
- Aged care nutrition could be included in national nutrition policy, guidelines, strategies and health campaigns

FINDING 22

Quality food is often seen as a luxury rather than a long-term preventative cost saving measure through forgone medical costs

Possible actions:

- Fund case study on cost savings of better quality food vs medication and nutritional supplements



Oral health, swallowing and hydration

Oral health, swallowing and hydration

A significant proportion of hospitalisations in aged care are related to dental health or swallowing issues, yet it is not widely recognised as a problem. The IDDSI (International Dysphagia Diet Standardisation Initiative) system is an important framework here but is relatively new and has not been fully implemented. Many of our residents will not escape the reality that food will need to be adjusted or pureed to accommodate dental or swallowing issues yet what is offered can be unappetising, flavourless food in "4 shades of brown".

> "Oral health still sits outside general health, that is something that we definitely need to change. Residents need holistic care that covers all the general health needs with their oral health needs.

FINDING 23

Dentists have trained other professions to do their job, but in Aged Care we need to have qualified dental practitioners available on-site

Possible actions:

- Have a qualified dental practitioner, dental hygienist, or oral health service available on-site to identify resident needs and liaise with dentists and other allied health workers

FINDING 24

There are barriers to getting dentists in e.g., funding, access, knowledge

Possible actions:

- Incorporate dental practitioners into the clinical model of care
- Relook at why dental care in Aged Care is not part of Medicare

FINDING 25

One of the highest preventable causes of death in Aged Care is choking risk. Family members often say that residents eat well when they are with them.

Possible actions:

- In addition to texture modification, it is the one-on-one attention that helps increase consumption. Trained staff who know the resident well can understand body language, verbal, and non-verbal communication. Assistance with sips of water.

FINDING 26

To maintain appetite appeal and consumption it is important that the skills of cooks and chefs are used to increase the aromatics and the flavour intensity.

Possible actions:

- Guidelines on texture is a good start but only a part of the process. There needs to be skills, experience, and training in the creation of appetising nutritious foods that residents will want to eat

FINDING 27

Collaboration between allied health, clinical staff and cook staff is often missing. The fragmentation in aged care service delivery results in serious implications for residents.

Possible actions:

- Redesign the use of screening tools, the care plans, the dining room support and the menus to ensure a holistic understanding and delivery of food experiences for each resident.
- Relook at education in Aged Care where all the staff engaged in Aged Care understand each other's role

FINDING 28

Some residents are coming into Aged care with significant dental issues

Possible actions:

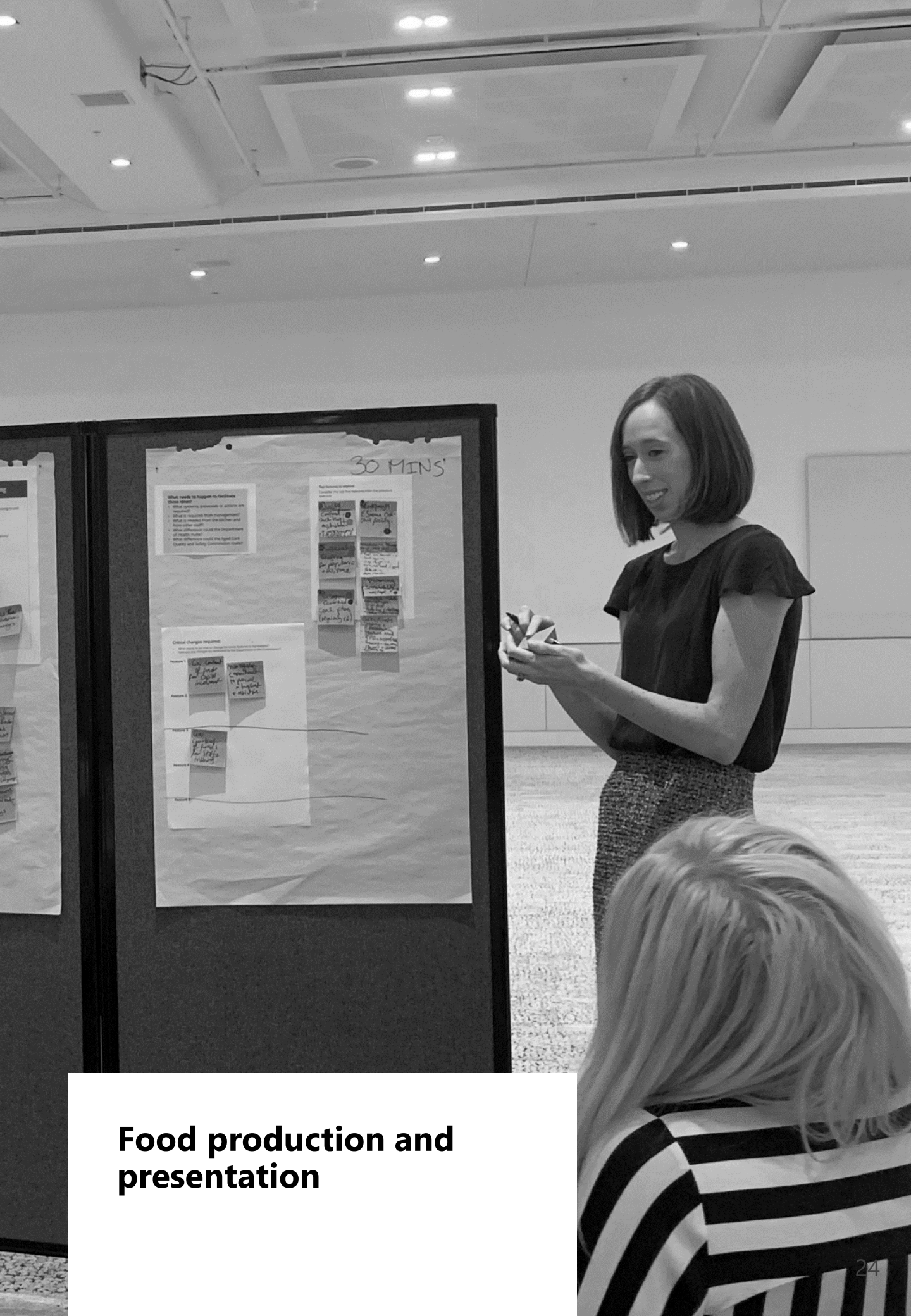
- Review the Medicare coverage of dental examination costs for older Australians (75+)

FINDING 29

GPs are already paid to do a 75yr old health check, but checking the oral cavity is not part of this check

Possible actions:

- Require GPs to examine the oral cavity and ask questions about dental and oral health practices within this health check



Food production and presentation

Food production and presentation

The Royal Commission final report states that meals should be desirable to eat. This is important both from a quality of life and a nutrition point of view. If food is visually appealing and tastes and smells good, people are likely to enjoy the experience, eat more and be better nourished. Cooks, chefs and other kitchen staff need to have the appropriate infrastructure, training and capability to produce nutritious, appetising, culturally appropriate food that tastes and looks good and is served at an appropriate temperature.

> “ Food that is not eaten is not nutrition.

FINDING 30

Food in aged care tends to be visually unappetising and nutrient-poor

Possible actions:

- Create instructional guides on best practice food presentation techniques focusing on elevating visual appeal - especially for modified food.
- Create guides with tips on how to 'hide' nutrient rich foods in other food products to make meals more nutrient dense (ie. Black beans and sweat potato becoming chocolate pudding)

FINDING 31

Food is often processed and pre-cooked off-site

Possible actions:

- Enable kitchen to cook fresh upgrades and buffet services

FINDING 32

Some facilities do not have access to fresh, local food suppliers

Possible actions:

- Enabling local food sourcing through Government food supply contracts
- Create grants to upgrade and digitise kitchens - reprioritising chefs focus to production and presentation of food

FINDING 33

Chefs play a role as both hospitality and clinical staff, but don’t always have a voice to make decisions as the latter

Possible actions:

- Encourage chef placement on facility management boards

FINDING 34

Many aged care facilities do not track or monitor quality of food

Possible actions:

- Define what is meant by Quality of Food by breaking it down into possible levels (e.g. nutritional value, sensory characteristics, resident acceptability, freshness and presentation)
- Give access to existing food quality measurement tools and provide funding for measurement on an ongoing basis

FINDING 35

Many aged care homes do not spend adequate amount of money on food for their residents

Possible actions:

- Enforce a minimum financial spend per person per day

FINDING 36

Many facilities do not track whether food is being eaten to figure out if there is a problem

Possible actions:

- Devise process to measure and report on appetite, consumption, plate waste

FINDING 37

Residents want to have their food fit for their tastes and dietary needs, but there are too many residents for carers to know their preferences in detail

Possible actions:

- Provide guides and training for kitchen staff on how to track and tailor resident preferences and food modifications - enabled by a single customer view
- Provide guidance from management around suggested standards and best practice examples
- Provide food preferences, nutrition requirements and texture levels on care plans

FINDING 38

Residents require specialised food preparation, but often chefs are not trained to make modified foods appealing or are restricted from ingredients that residents enjoy.

Possible actions:

- Create accredited training for chefs focused on texture modified food and
- Including texture modified food in school curricula to cover broader areas such as disabilities and childcare
- Create a forum to challenge restricted items
- Work with chefs to evaluate food risk standards

FINDING 39

Many chefs are unaware of the equipment available to assist with texture modified food preparation

Possible actions:

- Enable the purchase of equipment for chefs and kitchen environments
- Provide awareness of best practice examples
- Provide information on different equipment and techniques available to make texture modified food

Menu planning and innovation

Menu planning and innovation

Menus in aged care services often lack any input from residents. When combined with ad hoc menu review structures, failure to reflect diverse cultures in menu options and a lack of nutrition guidelines this creates a storm of unsatisfying and non-nutritious meals which may not be eaten at all.

> "In Canada, it's actually mandatory that all menus are reviewed by Resident Council Associations.

FINDING 40

Lack of menu rotation discourages residents from eating

Possible actions:

- Implement policy for menu re-evaluation after a defined amount of time. (ie. Menu plans for 3-4 weeks and then rotated, plans reviewed 2x a year)
- Support IT upgrades to support implementation of menu design, planning and evaluation systems
- Implement resident 'Foodie Groups' and other engagement tools to provide new menu options
- Encourage the more rigorous regulation of existing standards requiring menu consultation with older citizens

FINDING 41

Facilities do not have the resources to celebrate cultural diversity of residents

Possible actions:

- Generate educational materials to demonstrate diversity and cultural inclusion across menu options, language, and other cultural affinity
- Fund research into how to incorporate cultural preferences into aged care

FINDING 42

Facilities want to improve residents' nutrition, but don't have the resources to create holistic approach

Possible actions:

- Develop holistic food strategies and menu frameworks in conjunction with Government, chefs, nutritionists, oral health, allied health, etc.
- Create the cost of food services and food budget guidelines conducted by experts and economists.

FINDING 43

Residents consuming thickened liquids to meet dietary standards are often still under-hydrated

Possible actions:

- Develop educational materials that teach staff the importance of consuming required amounts of excess liquid to meet hydration targets
- Trial the use of commercial thickened drink products instead of drink products made on the premises to see if this increases hydration status

FINDING 44

Resident involvement is important

Possible actions:

- Implement resident involvement policy in menu planning through food focus councils made up of residents and families.
- Require a dedicated resident advocate role to liaise between the staff, residents, and Allied health to represent residents needs and set resident expectations.
- Provide case studies on successful resident cooking programs that allow residents to cook for themselves and serve to other residents throughout the facility.

Dining experience

Dining experience

Cooking and dining environments in aged care services are often designed with efficiency in mind, ignoring the residents' perspective on the dining experience and the community aspect of eating. Open style kitchens engage all of the senses, spurring food intake. Relationship centred care can also capitalise on mealtimes to create connections with residents, learn their dietary preferences on a personal level and investigate residents' food concerns

> "Food is central to how, why and when we connect with others at significant points throughout our lives, and it's critical to how we express ourselves as individuals over the life course including in our later years.

FINDING 45

Residents want personal relationships with carers, cooks and chefs and dining room staff but ratios make it hard to develop deeper relationships

Possible actions:

- Create staff to resident ratio requirements for acceptable rostering
- Create resident engagement programs with food experiences

FINDING 46

Residents want a hospitable dining environment to feel at home, but facilities don't always have the staff expertise to deliver

Possible actions:

- Create best practice guides on how to encourage family involvement on an ongoing basis
- Create best practice guides for lifestyle team that includes conversational training and other support for resident social interactions

FINDING 47

Dining and cooking environments are often designed for commercial cooking rather than to mirror the kitchens that residents recognise

Possible actions:

- Create resident centred best practice guide for cooking and dining spaces.
- Include guides for building and facility renovation that outlines best practice dining spaces for smaller communities and families
- Include guides for deinstitutionalised view to help residents feel at home

FINDING 48

Residents want the same flexibility in meal and snack times as they are used to outside of care.

Possible actions:

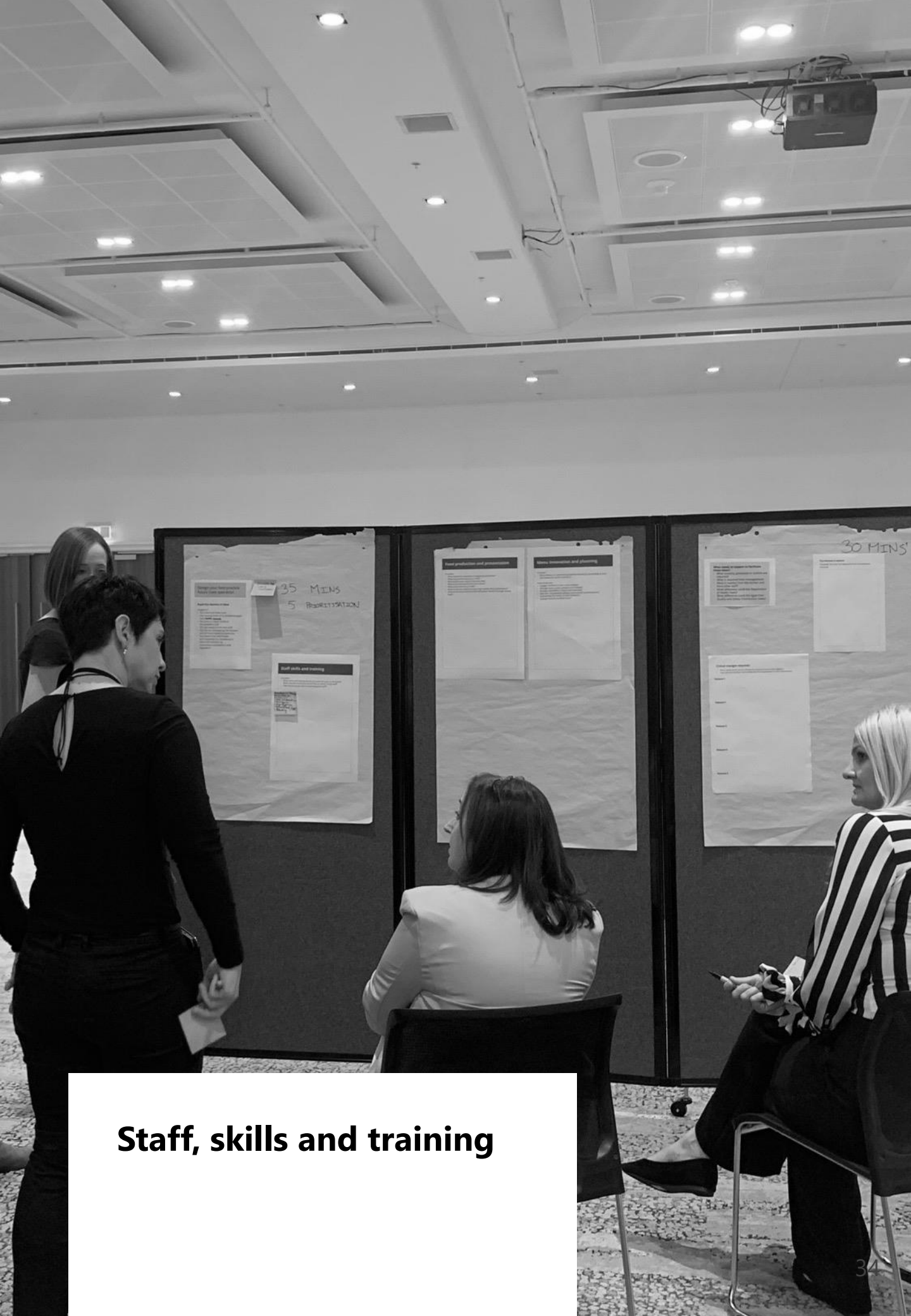
- Create guidelines and procurement structures to enable out of hours snacking and embrace autonomy
- Staffing requirements to provide minimum level of food service outside of meal times

FINDING 49

Older aged care facilities sometimes lack the physical spaces needed to provide optimal care and it is expensive to modernise

Possible actions:

- Invest in capital infrastructure for facility modernisation
- Create a process to identify and showcase best practice such as finishing kitchens
- Showcase 'small household' models of accommodation that have enabled providers to reach high standards of food and nutrition outcomes



Staff, skills and training

Staff, skills and training

Aged care requires specific knowledge that is not currently provided at traditional higher education institutions. While more general aged care skills of staff are critical to positive resident experiences, new staff should also be trained specifically in nutrition, texture modification, dementia, empathy to eating preferences and common ailments. Congress attendees agreed that training and retaining capable staff is a key enabler to the future of aged care . The final report of the Royal Commission has an emphasis on training and qualifications for staff.

> “ From Dementia Australia’s perspective the single most practical/realistic action to improve the food, nutrition and dining experience for people living with dementia would be for all aged care staff to undertake mandatory dementia education that includes a focus on the mealtime experience. From the Maggie Beer Foundation perspective Chef qualifications need to be augmented with formal, structured, specialist education focusing on the needs of aged care residents

FINDING 50

Chefs often lack the resources or processes to develop food, texture and nutrition plans that harness multidisciplinary inputs.

Possible actions:

- Enable the employment of additional staff and execute on person centred food needs
- Involve a multidisciplinary team in producing the guidelines to implement a holistic approach of recommendations (Chefs, cooks, nutritionists, dietitians, speech pathologists, and dentists)
- Encourage facilities to utilise allied health professionals
- Conduct an audit of the infrastructure and staff resources available in all homes

FINDING 51

A negative perception of aged care and lack of career path for cooks and chefs prevent potential talent from pursuing aged care.

Possible actions:

- Work with educational institutions and aged care facilities to create a career path for aged care chefs that spans from training through to management
- Create and encourage pathways for talent to enter aged care
- Create a professional association for aged care chefs to advocate for the industry and provide feedback on an ongoing basis
- PR to reframe Aged Care jobs in a positive light
- Require that all homes have a qualified chef to manage food production, presentation and compliance with individual care plans
- Create mechanisms to reward chefs and cooks for the skills required in Aged Care
- Encourage all staff to complete online training modules in specific food and nutrition skills

FINDING 52

Residents require food to be prepared in specific ways, however, there is a lack of motivation for chefs to seek specialised training as it is not rewarded monetarily.

Possible actions:

- Recognise the specialised skillset of aged care chefs and raise the minimum wages for these positions
- Break down financial barriers to higher education by providing financial aid and student loans for aged care training
- Create demand for training by requiring that all homes have a chef with specific aged care qualifications

FINDING 53

The 'plonkers' need to become 'engagers'

Possible actions:

- Provide training to those who serve food (personal care workers etc) so that they understand the importance of engaging with the resident, instead of plonking the food in front of them

FINDING 54

Chefs and other kitchen staff want to provide elevated food experiences for residents, but there is no centralised resource for best practices or to learn from their peers.

Possible actions:

- Build a centralised digital centre of excellence and community platform that will serve as a resource for aged care workers to access and contribute to best practice resources

FINDING 55

There is a lack of financial motivation for facilities to pursue higher levels of training.

Possible actions:

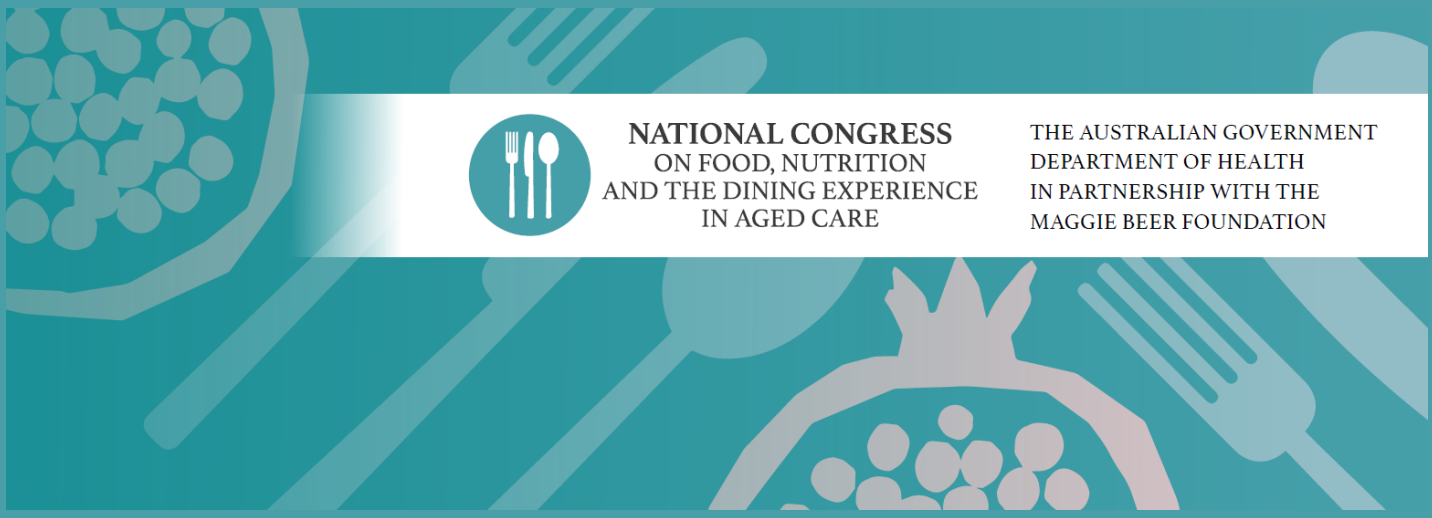
- Require a minimum standard of aged care training for industry staff as a pre-requisite
- Sponsor and create case studies that show the business benefit of continued staff training in order to drive cultural change that focuses on upskilling staff

FINDING 56

There is a lack of specific aged care training and qualifications

Possible actions:

- Create age care specific training led by the appropriate Government department and crafted by a multidisciplinary team that outlines an accreditation curriculum for staff that focuses on residents' specific needs.
- Increased regulation of Cert III of Individual Support for care workers
- Create an accreditation for resident facilities for having accredited staff and dedicated workers to focus on specific activities (chefs, dietitians, oral health therapists, etc.)
- Government to provide funding to assist in the development of training and apprenticeships
- Accreditation to include shared understanding of the importance of cultural knowledge across teams
- Accreditation to include training on empathy and common resident conditions
- Develop skills training in customer experience to understand the resident and certificates/qualifications in 'dining experience', outside of skills training
- Create training and best practice guides for ACQSC assessors that includes cultural, nutritional, and situational training so that maximum impact is gained from assessments
- Create opportunities for Continued Professional Development for chefs and other aged care staff to receive further training.
- Use policy to encourage innovation and student training in home simulations.
- Ensure that training programs incorporate an understanding of the changes in sensory perception, saliva production and specific cooking and finishing techniques necessary to provide foods that stimulate appetite and provide pleasure



NATIONAL CONGRESS
ON FOOD, NUTRITION
AND THE DINING EXPERIENCE
IN AGED CARE

THE AUSTRALIAN GOVERNMENT
DEPARTMENT OF HEALTH
IN PARTNERSHIP WITH THE
MAGGIE BEER FOUNDATION

Thank you.

To the Working Group and all of our partners and participants who made this Congress possible and helped to reimagine food, nutrition and the dining experience in aged care of the future.

Appendices

Background to the Congress Design

To meet the objectives of the Department of Health for a 'solution focused' event, the Maggie Beer Foundation designed a congress format rather than a conference. The difference between these two approaches is that a congress utilises forums and group discussions to provide workshopped outputs whereas a traditional conference utilises presentations and panels to inform an audience.

The congress design required an iterative process whereby a foundation of knowledge is built up prior to the Congress and disseminated to participants as pre-reading. The Congress itself was designed to utilise the expertise and experience of a representation of all peak bodies, allied health professionals, resident advocates, providers and Government departments to progressively convert the evidence and knowledge into findings and actions that will improve food, nutrition and the dining experience for older Australians.

01 Pre-reading deck

The intention of the pre-reading was to ensure that all participants in the Congress will have access to the same knowledge base. The three components of the pre-reading deck are:

Landscape Survey reports on a quantitative Survey of current food related practices in Australian Residential Aged Care homes.

The surveys were completed by 323 respondents representing 1282 Australian residential aged care homes and 90,936 residents. This represents 47% of aged residential care homes and 42% of the available residential age care places.

The report findings were conjointly prepared by the Australian Government Department of Health, Maggie Beer Foundation, CSIRO and University of South Australia. The Landscape Survey report is available separately from this Congress Report.

Literature Review examines the relationship between nutrition and quality-of-life (QoL) in older residents of long-term care facilities and the factors affecting this relationship. The review provides the Congress attendees a narrative synthesis of insights derived from 36 papers (submitted by the Working Group) from across the aged care literature and current best practice measures. The key themes and recommendations for discussion from these papers include:

- **Nutritional Guidelines in Aged Care**: How to more effectively educate, implement and evaluate the use of best-practice nutrition guidelines across the most appropriate segments of the Aged Care workforce.

(continued)

- **Food and Nutrition within Aged Care:** How to ensure that the nutritional needs of all residents are monitored routinely and met. The evidence suggests care staff need to be trained in how to conduct nutrition screening, and there is a call to action for nutrition managers and personal care staff to assist in the provision of care that is tailored to the needs of the resident.
- **Mealtime Experiences within Aged Care:** How to more effectively educate, implement and evaluate the use of best-practice guidelines across the most appropriate segments of the Aged Care workforce to enhance behaviour during mealtimes, particularly for those residents with dementia.
- **Innovation in Food Services within Aged Care:** How to more effectively implement and evaluate the effect of modifying the sensory, texture, and taste properties of meals, on quality of life and other important health outcomes including but certainly not limited to the emotional and nutritional status of residents.

In addition to the 36 papers, the findings from a systematic literature review on nutrition and quality of life (QoL) are included. These findings demonstrated a positive relationship between nutritional status and self-perceived QoL, and that nutrition support (which varied in nature) can improve QoL.

Also included in this report is a **narrative review on taste and age**, prepared by the Maggie Beer Foundation in conjunction with University of South Australia, Institute for Physical Activity and Nutrition (IPAN), School of Exercise and Nutrition Sciences, Deakin University. An often-under-appreciated factor contributing to malnutrition in older adults is the age-related change in taste perception. In this review we examine the factors that influence taste in older adults with a focus on findings from residential age care settings. This section concludes that strategies that improve food type, flavour perception, and the eating environment offer much promise in enhancing taste and, thereby, nutrition in older adults.

Collation of Manuals and Reports is an overview of published manuals and reports that the Providers of food in Residential Aged Care homes in Australia could use to guide best practice. This review demonstrates that there is a need for an up-to-date manual to give the providers of food and dining in Aged Care guidelines, practical information and training.

02 Working group

Preparation for the Congress involved the formation of an informed Working Group who assisted in the design of the agenda, the identification of participants and the compilation of a pre-reading deck.

Members of the Congress Working Group

Australian Government
Department of Health

Australian Government
Department of Veterans' Affairs

Australian Government
Aged Care Quality and Safety Commission

Pat Sparrow
Chief Executive Officer
Aged and Community Services Australia (ACSA)

Amanda Fieldhouse
Policy Manager
Aged Care Guild

Eithne Irving
Deputy CEO, General Manager, Policy and Advocacy
Australian Dental Association

Jeannine Biviano
Executive Director Healthcare
Compass Group

Deloitte

Ian Yates
Chief Executive Officer
COTA Australia

Maree McCabe
Chief Executive Officer
Dementia Australia

Ngaire Hobbins
Dietitian
Dietitians Australia

Robert Hunt
Chief Executive Officer
Dietitians Australia

Mary Ann Geronimo
Director of Policy - Health and Ageing
Federation of Ethnic Communities' Council of Australia (FECCA)

Professor Julie Ratcliffe
QoL expert
Flinders University, College of Nursing and Health Sciences

Kerri Lanchester
GM - Member Relations
Leading Age Services Australia (LASA)

Maggie Beer Foundation

Sarah Brown
CEO, Purple House
National Advisory Group for Aboriginal and Torres Strait Islander Flexible Aged Care (NAGATSIAC)

Christine Day
Manager Operations & Special Projects
Older Persons Advocacy Network (OPAN)

Stephen Judd
Chief Executive Officer
Residential Aged Care representative

Dr Julie Cichero
Speech Pathologist
Speech Pathology Australia

Dr Simon Longstaff
Executive Director
The Ethics Centre

Dr Sandra Iuliano
Senior Research Fellow
University of Melbourne, Department of Endocrinology

03 Submissions

National Congress on food, nutrition and the dining experience in aged care

Submissions Received

Australian Dental Association
Australian Sociological Association
Compass Group
Dementia Australia
Dietitians Australia
FECCA
Julie Cichero
Lantern Project
Lyndoch Living
Maggie Beer Foundation
Meals on Wheels
Meaningful Aging
Moran Aged Care
National Aging Institute
Ngaire Hobbins
Nutrition and Catering Institute
Occupational Therapy Australia
Polio Australia
SA Dental Service
Sandra Iuliano
Skills IQ
Smooth Dining
Southern Cross Care
Speech Pathology Australia
Stephen Judd
Twilight Aged Care
William Angliss

Agenda

NATIONAL CONGRESS
ON FOOD, NUTRITION
AND THE DINING EXPERIENCE
IN AGED CARE

AGENDA | 18 February 2021 | International Convention Centre Sydney

Minister Colbeck

Maggie Beer

A select number of experts and stakeholders with a diverse range of perspectives are invited to participate in the National Congress, which will inform food and nutrition policy and practice in aged care.

The Australian Government Department of Health is partnering with the Maggie Beer Foundation in the delivery of a National Congress on food, nutrition and the dining experience in aged care.

National Congress Agenda

NATIONAL CONGRESS
ON FOOD, NUTRITION
AND THE DINING EXPERIENCE
IN AGED CARE

The Department of Health is seeking to explore policy options that would assist in improving food, nutrition and the dining experience in aged care. To this end, we are inviting a diverse range of experts to give their views, in addition to hearing from those with lived experience of food and dining in aged care.

Objectives of the National Congress

- Bring together key stakeholders to provide diverse perspectives and expertise
- Identify contemporary literature and examples of best practice
- Provide key findings about how to improve nutrition and food experience for older Australians in aged care
- Inform future Government policy options relevant to food and nutrition in aged care

18 February 2021 (all invitees)

Time	Topic Description	Format	Speaker(s)
8:00 – 8:30	Registration		
8:30 – 8:40	Welcome to Country		Brendan Kerin
8:40-9:25	The importance of food	Presentation	Prof Wendy Lacey (Session Chair) Senator the Hon Richard Colbeck Maggie Beer AM
9:25 – 10:45	Best practice – Australia and around the world	Presentation	Edwig Goosens, Center for Gastronomy, Belgium Dr Heather Keller, Chair in Nutrition and Ageing, University of Waterloo, Canada Dr Cherie Hugo, Lantern Project, QLD Barry McKibbin Hospitality Services Manager, Anglican Care, Newcastle, NSW
10:45 – 11:15	Demonstration Compass Group		
11:15 – 12:00	Consumer choice and dignity	Panel	Christine Hopwood, Michael Monteleone Linda Elliot, Dr Simon Longstaff
12:00 – 12:45	Nutrition	Panel	Ngaire Hobbins, Sarah Brown Julie Dundon, Julie Reeves
12:45 – 13:30	Lunch		
13:30- 14:15	Oral health, swallowing and hydration	Panel	Dr Angie Nilsson, Dr Julie Cichero Janet Wallace, Amanda Orchard
14:15 – 15:30	Experiential Focus: - Dining experience & mealtimes - Resident menu requirements	Group activity	Facilitators
15:30 – 16:00	Demonstration Smooth Dining		
16:00 – 17:15	Operational Focus: - Food production and presentation - Menu planning and innovation - Staff, skills & training	Group activity	Facilitators
17:15 – 17:45	Summary & close	Presentation	Robbie Robertson

Congress Workshop Agenda

NATIONAL CONGRESS
ON FOOD, NUTRITION
AND THE DINING EXPERIENCE
IN AGED CARE

Objectives of the Workshop

On 19 February the Congress Working Group will reconvene to consolidate the discussions at the National Congress and produce key findings that the Department of Health can use to develop policy options for Government.

19 February 2021 (Working Group)

Time	Topic Description	Format	Speaker/s
8.45 – 9.00	Arrive		TBC
9.00 – 9.05	Welcome and Workshop design		Robbie Robertson
9.05 – 9.25	Fireside chat	Open discussion	Maggie Beer Melanie Wroth Josh Maldon
9.25 – 9.55	What are our desired destinations?	Group activity	Facilitators
9.55 – 10.15	Groups report back		Robbie Robertson
10.15 – 10.45	Morning tea		
10.45 – 11.30	How do we get to our desired destination?	Group activity	Facilitators
11.30 – 12.00	Groups report back		Robbie Robertson
12.00 – 12.15	Close with acknowledgements		

Partcipants

Organisation	Attendee name
Abbott	Mark Wilson
Aged & Community Services Australia	Julie Anderson
Aged & Community Services Australia	Pat Sparrow
Aged Care Quality and Safety Commission (ACQSC)	Gerard McNamara
Aged Care Quality and Safety Commission (ACQSC)	Catherine Meatheringham
Aged Care Quality and Safety Commission (ACQSC)	Belinda Newley
Aged Care Quality and Safety Commission (ACQSC)	Melanie Wroth
Aged Care Quality and Safety Commission (ACQSC)	Tim Yap
Ageing and Sociology Thematic Group, La Trobe University	Lucinda Aberdeen
Ageing and Sociology Thematic Group, Monash University	Maho Omori
Allity	Ian Tice
Altura Learning	Yvie Webley
Alzheimers WA	Warren Harding
Anglican Care Hospitality Services	Barry McKibbin
Anglican Church of Southern Queensland	Karen Crouch
Australian Association of Gerontology	James Beckford-Saunders
Australian Dental Association	Mikaela Chinotti
Australian Dental Association	Eithne Irving
Australian Dental Association	Angie Nilsson
Australian Nursing and Midwifery Federation	Julie Reeves
Beauaraba Living	Alex Metcalf
Bupa Australia	James Wix
Calvary Care	Colin McDonnell
Carers ACT	Phoebe Zardo
Carers Australia	Sue Elderton
Caring Futures Institute, Flinders University	Julie Ratcliffe
Catholic Healthcare	Sheridan Fredericks
Compass Group Australia	Jeannine Biviano
Compass Group Australia	Shelly Roberts
COTA Australia	Ian Yates
CSIRO	Pennie Taylor
Dairy Australia	Rivkeh Haryono
Deloitte Australia	Neha Chandra
Deloitte Australia	Estelle Couret
Deloitte Australia	Kyle Craft
Deloitte Australia	Vanessa Matthijssen
Deloitte Australia	Julie Miller
Deloitte Australia	Robbie Robertson
Dementia Australia	Caylie Field
Dementia Australia	Maree McCabe
Department of Health	Emma Cook
Department of Health	Tiali Goodchild

Partcipants

Organisation	Attendee name
Department of Health	Josephine Hermans
Department of Health	Alice Knight
Department of Health	Edgar Linder
Department of Health	Joshua Maldon
Department of Health	Margaret Noris
Department of Health	Prity Parry
Department of Health	Thomas Stoddart
Department of Health	Jemma Thompson
Department of Primary Industries	Lisa Szabo
Department of Veteran Affairs	Alexandra Kellar
Diabetes Australia	Natalie Luscombe-Marsh
Dietitians Australia	Julie Dundon
Dietitians Australia	Robert Hunt
Donwood Community Aged Care Services Inc	Binu Krishnan
Elders Rights Advocacy Group	Christine Hopwood
Federation of Ethnic Community Council of Australia	MaryAnn Geronimo
Food Standards Australia New Zealand	Angela Davies
Hall and Prior	Jess Zilujko
HammondCare	Sarah Brown
HammondCare	Peter Morgan-Jones
Holy Family Services	Alexandra Davis
Kalyra Communities	Sara Blunt
Kalyra Communities	Andrew Smith
Leading Age Services Australia	Ian Poalses
Lifeview	Madeline Gall
Lutheran Services	Nick Ryan
Lyndoch Living	Doreen Power
Maggie Beer Foundation	Maggie Beer
Maggie Beer Foundation	Libby Davies
Maggie Beer Foundation	Lynn James
Maggie Beer Foundation	Peter Kenny
Maggie Beer Foundation	Amanda Orchard
Maggie Beer Foundation / COTA SA	Jane Mussared
Maggie Beer Foundation / University of South Australia	Kurt Lushington
Masonic Care Tasmania	Katie Cooley
McKenzie Aged Care	Sam Coady-Shiels
Meals on Wheels Australia	Sharyn Broer
Meals on Wheels Australia	Evan Hill
Meals on Wheels Australia	Chris Watt
Meaningful Ageing Australia	Ilsa Hampton
Moran Aged Care Kellyville	Jennifer Dempsey
Ngaire Hobbins Aged Care Consulting	Ngaire Hobbins

Partcipants

Organisation	Attendee name
Northern Nutrition & Dietetics	Stephen Hodgkinson
NSW Rural Doctors Network	Nicole Turner
Nutricia Specialised Nutrition	Kath Collins
Nutrition and Catering Institute Limited	Karen Abbey
Nutrition Australia	Lucinda Hancock
Nutrition Australia	Amber Kelaart
Occupational Therapy Australia	Linda Elliott
Older Persons Advocacy Network	Christine Day
Older Persons Advocacy Network	Craig Gear
Palliative Care Australia	Jodie Ellis
Pennwood Village / Pennwood Home Care	Kimberley Moss
Polio Australia Incorporated	Melinda Overall
Purple House	Sarah Brown
Queensland University of Technology	Conor Brophy
Queensland University of Technology	Helen Edwards
Residential Aged Care Representative	Stephen Judd
SA Dental Service	Mark Chilvers
SA Dental Service	Adrienne Lewis
SkillsIQ Ltd	Yasmin King
Smooth Dining	Ben Cook
Sodexho	Michael Foenander
Southern Cross Care	Jo Boylan
Speech Pathology Australia	Julie Cichero
Speech Pathology Australia	Kym Toressi
St Andrews Village	Deborah Booth
St Luke's Care	Dominique Heitz
Stroke Foundation	Melita Guy
TAFE NSW	Suzanne Robertson
TAFE NSW	Nerida Volker
The Ethics Centre	Simon Longstaff
The Lantern Project	Cherie Hugo
The University of Sydney, School of Dentistry	Janet Wallace
Twilight Aged Care	Domenic Morabito
Unilever	Olena CheongFoo
Uniting	Craig Kirkpatrick
University of Canberra	Wendy Lacey
University of Melbourne	Sandra Iuliano
Victorian Aboriginal Community Controlled Health Organisation	Noeleen Tunny
Waltanna Farms	Michael Nagorcka
Whiddon	Michael Monteleone
William Angliss Institute	Ray Petts
Woodport Aged Care Centre	Nina Tangaroa