Australian Government
Aged Care Quality and Safety Commission

Food, dining and nutrition

Complaints to the Commission about food, dining and nutrition (2018-2020)

What do they tell us?

Introduction

To better understand the consumer food and dining experience, the Commission appointed Health Outcomes International (HOI) to analyse food related complaints received by the Commission for the three calendar years 2018 to 2020 related to residential aged care.

This paper summaries the findings and recommendations in the *Health Outcomes International Final Report on the Assessment of Food Related Complaints in Residential Aged Care Services.*

Project Aim

The aim of the HOI Assessment of Food Complaints was to identify, categories and quantify the main complaint issues lodged in relation to food and drinks, dining and nutrition in residential aged care during the 2018, 2019 and 2020 calendar years and to use this analysis to inform recommendations for consideration by the Commission.

A final dataset comprising of 4,900 records was available for quantitative analysis. A random sample of 934 cases across the three years was further explored for qualitative analysis.

The overall food and dining experience in residential aged care discussed in paper is informed by data specific to complaints lodged with the Commission and therefore not necessarily representative of all residents across Australia.

Findings

Complaints were assigned to one of eleven categories. The categories with the greatest proportion were "Meal or Food Quality", "Quantity, frequency or accessibility of food or drink" or "Food service" (including assistance, supported feeding, staff interaction and hygiene). See Appendix 1 for the number and percentage of complaints in each category.

A summary of each category, in order of most frequent to less frequent is below:

1. Meal or food quality

Across all three years, issues with the quality of meals and food were those most commonly reported. These included reference to taste, smell, appearance, texture, temperature, consistency and freshness.

Overcooking of vegetables or meat was more frequently cited than undercooking and contributed to meals described as flavourless and unpalatable. There was a number of issues specific to the quality of ingredients used to prepare the meals; specifically fruit, vegetables or meat. Poor quality of meals was considered a result of "cost cutting" measures in place within the service and the need to source cheaper ingredients. The standards in place for chef and kitchen staff qualifications or experience were criticised. As too was increasing reliance on external providers for food preparation which in turn impacted quality and freshness of meals.

Of significant concern were suggestions the food was not prepared or cooked appropriately for residents or appropriate hygiene practices were not followed.

Many complainants reported that meals and beverages were often cold. This was attributed to size of the dining room or service itself but also time taken to deliver meals to individual rooms as needed. It was often commented that due to insufficient staff available to provide the necessary assistance to residents at mealtime, food would be cold once such assistance did become available.

2. Quantity, frequency or accessibility of food or drink

Second to quality of meals and beverage were issues related to quantity, frequency and accessibility of food and drink. Many comments were made about small portion sizes that did not satisfy the appetite of residents. It was also suggested that there was little or no access to snacks in between meals, in particular fruit. A number of complainants observed resident weight loss and felt compelled to bring in food to supplement the meals provided.

Lengthy time periods between meals (particularly dinner and breakfast) resulted in residents feeling hungry later in the evening. Insufficient or no access to food or drinks outside of set mealtimes was also reported.

It was suggested that requests for second courses were rarely met due to insufficient food quantity to extend to additional servings. Complainants reported that if a resident was asleep or not able to attend the dining room, then they would not receive a meal at all.

Accessibility of food refers to not only being able to find a snack, prepare a warm drink or purchase additional meals as required, but also issues with independent feeding. This could include not providing the resident with the necessary eating utensils (closed cups, handles, or straws) to feed themselves or having a tray of food or jugs of water out of resident reach. Accessibility also refers to the consistency of food and whether it is appropriate for individual resident needs (for example serving sandwiches to a person on a pureed food diet or experiencing challenges chewing or swallowing).

There were additional concerns reported regarding access to adequately trained staff to support people who required some degree of specialised assistance to eat their meals. As a consequence, residents who may struggle with poor appetite or the ability to eat independently may not receive adequate nutritional intake.

More serious allegations were in regard to the deliberate withholding of meals or preventing a resident from accessing food when hungry.

3. Food service (including assistance, supported feeding, staff interaction and hygiene)

Interactions with staff were often discussed in food service issue summaries. This included concerns regarding assistance with feeding and whether particular staff had the appropriate skills for this role. Whilst some negative comments were made in relation to how individual staff members would interact with residents during mealtimes, a more common observation was that there were insufficient staff to deliver meals and provide the necessary assistance to residents. Staff were often "rushed" to ensure all residents were fed during the time allocated which introduced pressure on residents to hurry their meal, and also potential safety issues (hot beverages or choking hazards). Some complainants reported sympathy for staff preparing, providing and assisting with meals and felt they were doing "the best they can".

Some complainants perceived poor or inadequate training for staff to provide the necessary support with food introducing particular risks for some residents. Staff fatigue was also linked to compromised care or safety.

Pressure to work within set times introduced issues with some residents purportedly not receiving meals. This was often due to a resident not being awake when a tray was delivered to their room and then collected soon after without being touched by the resident.

It was also the case there were insufficient staff or time available to provide the necessary mealtime encouragement and assistance to those residents with poor appetites or disinterest in eating.

Additional issues were raised with regard to staff hygiene practices during mealtimes. This included appropriate handling of utensils, distribution/serving of food and washing of hands between supporting residents with their meals.

4. Food choice and diversity

Lack of choice, variety and diversity in menus were frequently reported by complainants. Some were concerned that despite specific meal requests, these selections were not adhered to. Issues were also raised in relation to choice over timing of their meals. Sometimes residents were not provided with a menu or were not aware of the choices available to them. The lack of variety in their diet was suggested to be inhibiting desire to eat for some residents and resulting in loss of weight, dehydration and malnutrition.

The lack of choice and diversity in meals were particularly pertinent for people with specific dietary requirements.

5. Appropriate nutrition

Insufficient access to dietitians and speech pathologists to inform appropriate menus for individual residents as needed was reported in a number of cases. There were also concerns that resident nutritional plans in place were not adhered to. Requests for a dietitian to undertake a formal review of the nutritional quality of the menu for all residents was often cited. In particular were comments regarding lack of fresh fruit and vegetables and sufficient protein for some residents.

For some residents with cognitive impairment or dementia there were concerns they were not appropriately encouraged eat sufficiently; thereby not meeting nutritional requirements. It was suggested that greater monitoring of residents with cognitive impairment for daily nutrition and hydration is necessary.

6. Meal preferences or dietary requirements

This category encompasses issues specific to whether food preferences of a resident are being met, including cultural or religious. This also includes an understanding and accommodation of individual personal food preferences; what a person does or does not like to eat. This could be specific to diets suitable for a diabetic, gluten intolerance or food allergies. Complaints often focused on inappropriate food being provided to those with specific dietary requirements; intentionally or unintentionally.

Cultural or religious preferences were not always considered during meal preparation or serving.

Conflicts arose where there were disagreements between what the resident may request and recommendations or wishes of the family.

Some families have endeavoured to ensure residents receive meals with which they are familiar, or they know they will enjoy. However, acceptance of this practice can vary between sites.

7. Liquid hydration, fluids or water

Lack of access to adequate fluid, most commonly water, was frequently reported. Insufficient hydration was attributed to jugs not being refilled, residents not being encouraged to drink and access to fluids in themselves. This included the cup and jug being place out of reach of the resident, or straws not being provided to enable independent access.

Concerns about hydration were often based on family observation of empty water jugs, cracked or dry lips, dark coloured urine, bad breath or frequent urinary tract infections.

8. Weight loss or gain

Fluctuations in weight were attributed to insufficient quantity of food, inadequate nutrition and poor monitoring of dietary intake. This also included lack of staff available to support or encourage residents to eat their meals. Residents with poor appetites or challenges eating independently appeared particularly affected by weight loss in this sample. Weight gain was attributed to inappropriate choices of food or residents consuming greater amounts of "unhealthy" foods due to dislike of the choices on offer at mealtimes.

Loss of weight was also considered a result of poor oral health, including mouth abscesses and ill-fitting dentures. Inappropriate foods provided to the resident were associated with reduced food intake and subsequent weight loss.

9. Teeth, swallowing, chewing or choking

There were frequent mentions of poor attention paid to oral hygiene across the sample. These included staff not encouraging or assisting residents to brush their teeth regularly and properly, and poor management of denture cleaning. They also referred to missing toothbrushes and dentures themselves. Issues with teeth and ill-fitting dentures were affecting the resident's desire and ability to eat and drink. Family members reported that they were not contacted with oral health concerns (such as the need to replace dentures) or their requests for greater attention to this aspect of hygiene were ignored.

Also concerns regarding ongoing management of issues with swallowing for some residents were reported.

10. Dining environment (including access)

Issues specific to the dining environment comprised those related to general hygiene, accessibility, smell, sound and overall ambience. This category also included comments regarding access to sufficient crockery and cutlery for residents or serving utensils. Observations of poor hygiene were associated with the dining room equipment and furniture and staff preparing and serving the meals to residents. There was also a small number of comments specific to how food is set out for residents to access independently (such as a bowl of fruit or plate of biscuits).

11. Other

Fear of reprisal or negative consequences was commonly referred to in the issue summaries. This included that reported on behalf of residents or by family members themselves. Feedback on quality of food and service had been raised through a range of avenues such as resident meetings and written and verbal feedback to staff and management. Many reported frustration at the general inertia in response to this feedback.

However, more serious were suggestions that residents, and family members/advocates were frightened or intimidated by particular staff (including the chef/kitchen staff). A number of family members had introduced their own systems of ensuring the resident received quality meals and beverages by bringing home cooked meals into the facility, negotiating a small fridge and/or microwave into the resident's room, or provision of a range of snacks and other sources of food they felt would please the resident.

Although infrequent, a small number of family members expressed upset at not being able to join the resident on occasion for a meal within the dining room; often based on cost or service policy. For some residents, the presence of a family member at a weekly meal was comforting and familiar. Family members also suggested that the resident would tend to eat more with family present. Not only due to their company in itself but also because the family member could provide tangible assistance to the resident as needed.

Recommendations

Health Outcomes International made twelve recommendation for the Commission and the aged care sector based on their assessment of food related complaints.

In 2020 the Aged Care Quality and Safety Commission (the Commission) commenced a campaign on food and nutrition to support high quality, enjoyable dining experiences for residential aged care residents; build staff capability to identify and act early on areas that impact on eating; and meet the Aged Care Quality Standard on dignity of choice regarding food and meals. The Campaign is supported by a Food and Nutrition Expert Advisory Group[1].

Work that is underway as part of this Campaign that can support providers to address recommendations are detailed in the box under each recommendation, in particular for recommendations 7, 9, 10, 11 and 12.

Recommendation 1: Food service budget review

Organisations are encouraged to review current budget allocation to ensure food services are allocated sufficient funds to purchase the necessary type, quantity, variety and quality of food necessary to fulfil necessary daily nutritional requirements and satiation, as well engage appropriately skilled staff to prepare and deliver quality meals. Service capacity to meet this recommendation will be significantly improved by an available increase in the daily fee supplement introduced in July 2021.

1 The Expert Advisory Group brings together wide-ranging expertise including in the areas of consumer advocacy, cultural and linguistic diversity, nutrition, food preparation and service, speech pathology, dementia care, wound care, and dental and oral health.

Average daily spend by older adults in the community, within similar institutionalised services, such as hospitals or prisons, and international aged care organisations can be used as a guide.

The Commonwealth Department of Health introduced the basic daily fee supplement in 2021. It provides an additional $10 per day, per resident.

The new supplement supports aged care providers to deliver better care and services to residents, with a focus on food and nutrition.

Recommendation 2: Evidence-based menu planning and assessment

Dietitians Australia recommends meal planning be based on meeting the specific nutrition and dietary needs of older adults. Where not in place at present it is recommended that dietitians and speech pathologists regularly review menu options to ensure these align with older adult dietary requirements, nutritional needs and safety of food consumption for residents experiencing issues with chewing or swallowing. This may include the use of the newly developed Menu and Mealtime Quality Assessment for Residential Aged Care Tool by Dietitians Australia (which aligns with current quality standards). Speech Pathologists can advise on consistency of foods and beverages specific to a modified texture menu for people with dysphagia (swallowing issues).

Recommendation 3: Routine malnutrition screening

Older people are at increased risk of unplanned weight loss and malnutrition. However, these risks can be greatly reduced by having evidence-based care strategies in place. Dietitians Australia recommends routine and ongoing malnutrition screening within aged care services. Multiple validated nutrition screening tools are available to determine the nutritional status of adults within aged care settings. Improved nutrition may be further supported through establishment of a multidisciplinary team to plan, implement and monitor food and nutrition services, with input from accredited dietitians.

The Commission's Expert Advisory Group developed a factsheet for consumers and providers (management and staff) on *nutrition and texture modified food*.

Recommendation 4: Support for independent food and drink consumption

Accessibility of food may be further promoted through provision of assistive mealtime eating and drinking utensils and placing food within sight and reach of the resident to encourage autonomy. This includes removal of plastic wrap, opening sachets or other assistance. It also refers to consideration of portion size, consistency and manageability (does it need to be cut up for example?) Independent eating should be encouraged as feasible through ongoing assessment of those individuals who may need assistance to eat particular meals and the degree to which this assistance is necessary.

Recommendation 5: Food delivery, timing and temperature management

Food service timing and delivery be considered to better accommodate resident needs and staff availability. This could include extended, greater staggering or flexibility of mealtimes to enable increased time with each resident as necessary. Temperature of meals can be monitored through use of appropriate food utensils, crockery and other equipment to accommodate distance from kitchen to dining room or individual rooms across the service and processes of delivery to individual residents regularly reviewed for opportunities for greater efficiency.

Recommendation 6: Staff training in meal planning, preparation and service

It is suggested that appropriately trained and experienced staff, as per particular task associated with meal preparation, serving and assistance with eating, be available during mealtimes to ensure residents receive their meals within a timely and safe manner. Dietitians Australia consider it necessary to increase the competency of aged care staff more generally through inclusion food and nutrition skills content in foundation education and training for personal care workers, chefs and foodservice staff and nurses.

Recommendation 7: Improved resident choice and experience

Mealtimes not only support good physical health, but a sense of social wellbeing, comfort, routine and familiarity for older people living in residential aged care services. Choice, including food choice, is fundamental to the Aged Care Quality Standards. Food presentation is also a key component of high-quality food service in residential aged care as satisfaction with meals contributes to food intake. Food provided must be nutritious, familiar, culturally appropriate, well presented and part of a positive mealtime experience. Regular and formalised collection and review of individual dietary, cultural, religious and personal food preferences will support satisfaction in meals provided and encourage those with poorer appetites to eat. It may also include observation of particular cultural or religious events. Residents should be encouraged to contribute to menu design and food options available to improve choice and variety of meals offered, including those on modified or specialised diets. Residents should be enabled to make their meal choice at the point of service, or as close as possible, rather than ordering prior to mealtimes. Innovative methods, such as assisted buffets, carts and room service, are potential options.

The Commission's Expert Advisory Group identified choice as one of the four priority areas to address to improve food, nutrition and dining in residential aged care.

The Expert Advisory Group has developed a suite of resources for providers (managers and staff) and consumers on choice including:

- *Making choices about your food and drink in residential aged care* (consumer factsheet)
- *Supporting informed choice about food and drink in aged care* (provider management and staff factsheets)
- *Supporting Informed Choice and Shared Decision Making for people who Eat /Drink with Acknowledged Risk* (consumer and provider factsheets)
- *Posters for consumers and staff on meal and dining choice and risk.*

Recommendation 8: 24-hour dining and access to fluids

Services to ensure snacks such as fruit or other nutritious food items are available throughout the day and between meals for residents ("24-hour dining") as appropriate. These may include yoghurt tubs, custard pots, cheese and crackers. To prevent dehydration, ready access to water, and other fluids for all residents is critical. This may include consideration of how this fluid is provided (to ensure resident can consume independently or with minimal assistance as needed), encouragement and support to regularly drink water for those who may need reminders, provision of preferred fluids (understanding what the resident would like to drink) and regular replenishment of water and drinking utensils (cups, straws, beakers or squeeze bottles). Daily fluid intake and sources should be monitored and recorded.

Recommendation 9: Assessment of dining room ambience and cleanliness

Dining rooms, including furniture, equipment, crockery and utensils require regular review for cleanliness and hygienic practices associated with meal service. Residents and family can provide feedback on the dining room itself as to how ambience and environment may be improved. This could also include consideration of the dining experience more generally (special events, lighting, sound, music, table settings, comfortable furniture and pleasant smells).

The Commission's Expert Advisory Group identified oral health and swallowing difficulties as the two key health issues that, if not addressed, impact on a person's ability to eat and drink.

The Expert Advisory Group developed a suite of resources for providers (managers and staff) and consumers on swallowing and oral health including:

Oral health

- *Know, Look, Act – recognising and responding to signs of poor oral health* (consumer and provider factsheets and posters).

Swallowing

- *Supporting Safe and Enjoyable Mealtimes for People with Swallowing Difficulties* (consumer factsheet and provider management and staff factsheets)
- *Nutrition and texture modified food* (consumer factsheet and provider management and staff factsheets)
- *Supporting Informed Choice and Shared Decision Making for people who Eat /Drink with Acknowledged Risk* (consumer and provider factsheets).

Recommendation 10: Systematic collection of consumer feedback

Residents and families must be provided with transparent and "safe" avenues through which issues with food services are able to be raised. These may include anonymous mechanisms, resident groups or ongoing food "satisfaction" surveys. Where consumers have difficulty communicating, alternative forms of communication must be implemented (for example those requiring a modified texture diet are often unable to speak but are at highest nutritional risk). Feedback collected is to be acknowledged and actions taken reported back to residents through regular and formal processes. This may include discussion on key challenges or factors to consider in the provision of food within the aged care setting.

Recommendation 11: Increased emphasis on oral health

Greater emphasis to be placed on ensuring oral hygiene, including frequent brushing of teeth and daily denture cleaning, to prevent issues with eating for residents. This may also entail seeking necessary care to respond to other issues affecting food and liquid intake such as dry mouth or ill-fitting dentures. Dieticians Australia recommend the establishment of a multidisciplinary team with members of the dental profession, speech pathologists and dietitians to manage the oral health, swallowing and hydration of aged care residents.

Consumer feedback is an area that the Commission has flagged for future work.

The Commission is talking with providers who have resident food committees to identify what works well in consulting with consumers. This information will be shared with providers later in 2023 as part of a toolkit to implement formal and informal food focus groups and/or resident food committees.

Recommendation 12: Further exploration of factors associated with food service satisfaction

Although not within the scope of the present project, it may be helpful to understand how the service model of care may influence frequency and type of complaint issues specific to food services. For example, how does a domestic home like care model, through which residents are involved in the weekly menu design, shopping in some cases and preparation of meals in small groups, compare with issues related to food occurring in more "traditional" service settings? Further qualitative research into the experience of older people living in residential aged care services, beyond those specific to complaints only, may also inform a more comprehensive view of food and dining services in these settings.

The Commission has engaged the Older Persons Advocacy Network (OPAN) to use their network of advocates to interview consumers in residential aged care about their food and dining experience.

This will allow the Commission to hear from consumers who do not raise complaints with the Commission, including from consumers with positive dining experiences. The findings from the consultations will be analysed and shared with the sector in a summary report and provider webinar later in 2023.

Appendix 1

Issues for each case record (complaint) were assigned to one of eleven categories (including Other). The table presents counts and percentage for each of these categories. Those categories with the greatest proportion included "Meal or food quality", "Quantity, frequency or accessibility of food or drink" or "Food service" (including assistance, supported feeding, staff interaction and hygiene).

Table 1: Counts per Coding Category

Coding Category	2018	2019	2020	TOTAL	%
Meal or food quality	124	116	89	329	19.8%
Quantity, frequency or accessibility of food or drink	108	106	66	280	16.9%
Food service (including assistance, supported feeding, staff interaction, hygiene)	62	100	105	267	16.1%
Choice and diversity	57	31	52	140	8.4%
Appropriate nutrition	48	30	55	133	8.0%
Meal preferences or dietary requirements	53	47	33	133	8.0%
Liquid, hydration, fluids or water	28	44	47	119	7.2%
Weight loss or gain	22	38	43	103	6.2%
Teeth, swallowing chewing or choking	20	24	25	69	4.2%
Other	11	16	27	54	3.3%
Dining environment (including access)	6	11	16	33	2.0%
All complaints	**-**	**-**	**-**	**1,660**	**100.0%**

The Aged Care Quality and Safety Commission acknowledges the Traditional Owners of country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to Elders both past and present.

This is a summary of a report prepared for the Aged Care Quality and Safety Commission by Health Outcomes International, *Assessment of Food Related Complaints in Residential Aged Care Services*, 2021

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