TITLE: AUDIT OF BEST PRACTICE FRAILTY CARE CAPACITY INCLUDING ROBUST EXERCISE WITHIN RESIDENTIAL AGED CARE FACILITIES IN NORTH QUEENSLAND

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INTRODUCTION & AIM: Best-practice frailty care in residential aged care homes (RACHs) requires coordinated, multidisciplinary approaches across clinical and organisational domains. Accredited Exercise Physiologists (AEPs) are increasingly delivering exercise interventions in RACHs, which is central to evidence-based frailty management. However, it is unclear whether the current national quality indicators, which RACHs are required to meet, are sufficient to encourage RACH providers to deliver evidence-based exercise as well as other components of best practice frailty care including nutritional fortification, medication optimisation, and social engagement, especially in regional/ rural areas. This study aimed to audit North Queensland (NQ) RACHs for gaps in frailty care, and assess readiness for regional/rural implementation of best-practice frailty care models including robust exercise. METHODS: Structured audits were conducted across three NQ RACHs. Audit criteria were informed by the Asia-Pacific Clinical Practice Guidelines for the Management of Frailty and outcomes from the FRIEND trial. Ten domains were assessed, including organisational policy, frailty screening and assessment, multidisciplinary care, medication management, physical infrastructure, care planning, software systems, workforce training, monitoring and evaluation, and stakeholder feedback. RESULTS: Audits identified the following gaps in frailty care: no facility had dedicated frailty policy/procedure; routine frailty screening, reassessment, and psychosocial evaluations were absent; multidisciplinary teams lacked consistent inclusion of social workers and AEPs; medication reviews lacked polypharmacy triggers, cascades, or alternatives; exercise infrastructure was limited, with inconsistent screening/monitoring; care plans rarely included exercise-based prescriptions or drug-nutrient/exercise interactions; software systems lacked real-time frailty tracking and integrated summaries; frailty-specific staff training was limited or non-existent; quality of life assessments beyond regulatory requirements were not routine; and structured stakeholder feedback on frailty care was underdeveloped. CONCLUSION: Significant, non-regulated gaps exist in frailty care across NQ RACHs. Strengthening integration of AEPs, alongside broader system, workforce, and infrastructure reforms, is critical to achieving best-practice frailty care in RACHs.