

New Dining Practice Standards

Focus 2012: Mission Possible!

Linda Bump, MPH, RD LD, LNHA



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The Big 2 Recommendations

- **National stakeholder workgroup develop guidelines for clinical best practice** for individualization to provide regulatory guidance and prepare related education materials to facilitate implementation.
- **Each profession serving elders in LTC develop and disseminate standards of practice for their professional accountability** that addresses proper training, competency assessment, and their role as an active advocate for resident rights and resident quality of life from a wellness perspective in addition to quality of care from a medical perspective.



National Standard Setting Organizations

1. American Association for Long Term Care Nursing (AALTCN)
2. American Association of Nurse Assessment Coordination (AANAC)
3. American Dietetic Association (ADA)
4. American Medical Directors Association (AMDA)
5. American Occupational Therapy Association (AOTA)
6. American Society of Consultant Pharmacists (ASCP)
7. American Speech-Language-Hearing Association (ASHA)
8. Dietary Managers Association (DMA)
9. Gerontological Advanced Practice Nurses Association (GAPNA)
10. Hartford Institute for Geriatric Nursing (HIGN)
11. National Association of Directors of Nursing Administration in Long Term Care (NADONA/LTC)
12. National Gerontological Nursing Association (NGNA)

New Dining Practice Standards Sections:

- **Diet Liberalization: Diabetic, Low Sodium, Cardiac**
- **Altered Consistency Diet**
- **Tube Feeding**
- **Real Food First**
- **Honoring Choice**
- **Shifting Traditional Professional Control to Support Self Directed Living**
- **New Negative Outcome**



Each Section includes:

- AMDA
- ADA
- CMS
- Research Trends
- Current Thinking
- Recommended Course of Practice



Changing Communities. Changing Lives.

Recommended Course of Practice

The following universal recommendations are repeated for these sections:

- Diet Liberalization
 - Diabetic/Calorie Controlled
 - Low Sodium
 - Cardiac Diet
- Altered Consistency Diet
- Tube Feeding



Changing Communities. Changing Lives.

Recommended Course of Practice

- Diet determined with the person **not** exclusively by diagnosis.



Changing Communities. Changing Lives.

Recommended Course of Practice

- Assess the **condition** of the person. Assess and provide the person's preferred context and environment for meals, in other words the person's preferences, patterns and routines for socialization (i.e. eating alone or with others), physical support (i.e. adapted eating utensils, assistance with cartons/cutting or adapted w/c positioning), timing of meals (i.e. typical community or unique meal times) and personal meaning/value of the dining experience (i.e. for one who does not eat breakfast, breakfast is not important but perhaps an early lunch is)...



Recommended Course of Practice

- Include **quality of life** markers such as satisfaction with food, service received during meals, level of control and independence.



Recommended Course of Practice

- Unless a medical condition warrants a restricted diet, **consider beginning with a regular diet** and monitoring.
- **Empower and honor the person first, whole interdisciplinary team second**, to look at concerns and create effective solutions.
- Support **self-direction** and **individualize** the plan of care.



Recommended Course of Practice

- Ensure that the physician and consultant pharmacist are aware of **resident food and dining preferences** so that medication issues can be addressed and coordinated i.e. medication timing and impact on appetite.
- **Monitor person and condition related to their goals** regarding nutritional status, physical, mental and psychosocial well-being.
- **Although a person may have not been able to make decisions about certain aspects of their life, that does not mean they cannot make choices in dining.**



Recommended Course of Practice

- When one makes “risky” decisions, **plan of care will be adjusted to honor informed choice, provide support to mitigate risks.**
- Most professional codes of ethics **require professional to support** the person in making their own decisions.



Recommended Course of Practice

- When caring for frail elders there is often no clear right answer. Possible interventions often have the potential to both help and harm the elder. This is why the physician must explain the risks and benefits to both the resident and interdisciplinary team. The information should be discussed amongst the team and resident/family. **The resident then has the right to make his/her informed choice even if it is not to follow recommended medical advice and the team supports the person and his/her decision, mitigating risks by offering support, i.e. offering foods of natural pureed consistency when one refuses recommended tube feeding.** It is when the team makes decisions for the person without acknowledgement by all that problems arise. The agreed upon plan of care should then be monitored to make sure the community is best meeting the resident's needs.



Recommended Course of Practice

- All decisions default to the person.



Diet Liberalization



Diet Liberalization AMDA

- One of the **frequent causes of weight loss** in the LTC setting is therapeutic diets. Therapeutic diets are often unpalatable and poorly tolerated by older persons and may lead to weight loss. The use of therapeutic diets, including low-salt, low-fat, and sugar-restricted diets, **should be minimized** in the LTC setting.
- **Attending physicians are encouraged to consider liberalizing dietary restrictions that are not essential to well being, and that may impair quality of life or acceptance of diet.**



Diet Liberalization ADA 2002

- It is the position of the ADA that the **quality of life and nut. status** of older residents in LTC facilities may be **enhanced** by **liberalization of the diet prescription**. Medical nutrition therapy **must balance** medical needs and individual desires and maintain quality of life. The recent paradigm shift **from restrictive institutions to vibrant communities** requires dietetics professionals to be open-minded when assessing risks versus benefits of therapeutic diets, especially for frail older adults.



Diet Liberalization ADA 2002

- Food is an essential component of **quality of life**; an unacceptable or unpalatable diet can lead to poor food and fluid intake, **resulting in weight loss and undernutrition and a spiral of negative health effects**.



Diet Liberalization ADA 2010

- It is the position of the ADA that the quality of life and nut. status of older adults residing in health care communities can be enhanced by **individualization to less-restrictive diets**.
- Although therapeutic diets are designed to improve health, they can negatively affect the variety and flavor of the food offered. Individuals may find restrictive diets unpalatable, resulting in reducing the pleasure of eating, decreased food intake, unintended weight loss, and undernutrition – **the very maladies health care practitioners are trying to prevent**.



Diet Liberalization ADA 2010

- In contrast, more liberal diets are **associated with increased food and beverage intake**. For many older adults residing in health care communities, **the benefits of less-restrictive diets outweigh the risk**.



Diet Liberalization CMS Tag 325 Nutrition

- Research suggests a liberalized diet can **enhance quality of life and nut. status of older adults** in LTC facilities.
- Thus, it is often beneficial to minimize restrictions, consistent with a resident's **condition, prognosis, and choices** before using supplementation.
- It may also be helpful to provide the residents their **food preferences, before supplementation**. This pertains to **newly developed** meal plans as well as to the **review** of existing diets.



Diet Liberalization CMS Tag 325

- Dietary restrictions, therapeutic and mechanically altered diets **may help in select situations**.
- At other times, they **may impair adequate nutrition and lead to further decline** in nutritional status, **especially in already undernourished or at-risk individuals**.
- When a resident is not eating well or is losing weight, the interdisciplinary team **may temporarily abate dietary restrictions and liberalize the diet to improve food intake to try to stabilize weight**.



Diet Liberalization CMS Tag 325

- Sometimes, a resident or resident's representative decides to **decline** medically relevant dietary restrictions. In such circumstances, the resident, facility and practitioner **collaborate to identify pertinent alternatives**.



Liberalized Diet Current Thinking

- Dr. Karyn Leible and Dr. Matt Wayne
The Role of the Physician Order, Creating Home II
- All persons moving into a nursing home receive a **regular diet unless there is a strong medical historical reason** to initiate/continue a restricted diet.
- Those who require medicalized diets can be **assessed** by the dietitian, physician and if necessary the speech therapist for appropriate individualized modification.



Liberalized Diet Current Thinking

- There needs to be **continuous monitoring** of the usage of all medicalized diets to ensure that they continue **to be medically indicated, much the same way the usage of urinary catheters or other medical devices are monitored**.
- When potential interventions have **the ability to both help and harm**, such as medicalized diets and thickened liquids, the interventions should be reviewed by the **IDT in a holistic fashion and discussed with resident and/or their family/POA prior to their implementation**.



Liberalized Diet Current Thinking

- Residents and/or their families/POA should be **educated** regarding these interventions and the care plan monitored for **both safety and effectiveness**.
- The physician and interdisciplinary team should treat asymptomatic disease **PROVIDED** it is consistent with the resident's goals for care, is **SUPPORTED** by the literature and **DOES NOT DECREASE QUALITY OF LIFE**.



Diabetic/Calorie Controlled Diet AMDA

- AMDA: "...**intensive treatment of diabetes may not be appropriate for all individuals in the LTC setting**. To improve quality of life, diagnostic and therapeutic decisions should take into account the patient's cognitive and functional status, severity of disease, expressed preferences, & life expectancy."
- An individualized regular diet that is **well balanced** and contains a **variety of foods** and a **consistent amount of carbohydrates** has been shown to be more effective than the typical treatment of diabetes.



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Diabetic Diet Current Thinking

- The only benefit to sliding scale insulin is with a new diagnosis where the clinician is attempting to estimate daily dosage of insulin. For this reason, insulin **sliding scale should be used sparingly if at all**, and **glucose monitoring should be done no more than once daily in stable diabetics**, more frequently, albeit temporary, if actively adjusting the regimen. Drs. Leible and Wayne, Creating Home II



Diabetic Diet Research Trends

- Recent studies have failed to show that tight glycemic control prevents heart attacks and strokes in diabetics and may in fact worsen outcome. Tighter glycemic control may prevent complications of retinopathy, neuropathy and nephropathy **in newly diagnosed diabetics** however these conditions take years to develop and **few, if any, older adults would benefit from this approach.**



Diabetic Diet Research Trends

- Given the lack of clear evidence to guide treatment in the older adult population, AMDA recommends individualizing the treatment plan based on a resident's underlying medical condition and associated co-morbidities and has stated a **target hemoglobin A1C between 7 and 8 is reasonable.**



Low Sodium Diet AMDA

- AMDA: Such dietary restrictions may benefit some individuals, but **more lenient blood pressure and blood sugar goals in the frail elderly may be desirable** while a less palatable restricted diet may lead to weight loss and its associated complications



Low Sodium Diet ADA

- ADA: Recommends **DASH -Dietary Approaches to Stop Hypertension:**
- known to reduce blood pressure,
- may reduce rates of heart failure.
- low in sodium, saturated fat, high in calcium, magnesium, and potassium.
- Nutrition care plans should focus on maintaining blood pressure and blood lipid levels while preserving eating pleasure and quality of life.
- Using DASH menus can help achieve those goals.



Low Sodium Research Trends

- The typical two gram sodium diet that is often recommended for individuals with hypertension, has been shown to reduce **systolic blood pressures, on average, by only 5 mmHg, and diastolic blood pressures by only 2.5 mmHg** making this diet's effect on blood pressure **modest at best** and **has not actually been shown to improve cardiovascular outcomes in the nursing home resident.**



Low Sodium Recommended Course of Practice

- Low sodium diets are not shown to be effective in the long term care population of elders for reducing blood pressure or exacerbations of CHF and therefore **should only be used when benefit to the individual resident has been documented.**



Cardiac Diet Current Thinking

- Limiting salt intake in individuals with congestive heart failure is felt to be of benefit by limiting fluid retention, but the clinical experience of two medical directors of numerous nursing homes shows that this is **necessary in only a minority of nursing home patients, usually those who are salt sensitive and often have advanced disease.**
- Drs Leible and Wayne, The Role of the Physician Order, Creating Home II



Cardiac Diet Research Trends

- The effects of the traditional low cholesterol and low fat diets typically used to treat elevated cholesterol vary greatly and, at most, will **decrease lipids by only 10-15%.**
- If aggressive lipid reduction is appropriate for the nursing home resident it can be more effectively achieved through the use of **medication that provides average reductions of between 30 and 40%** while still allowing the individual to enjoy personal food choices (2 research studies).



Cardiac Diet Recommended Course of Practice

- Low fat (low cholesterol) diets have only a **modest effect** on reducing blood cholesterol in the long term care elder population and therefore should only be used when benefit has been documented.



Altered Consistency



Altered Consistency CMS

Identification of a swallowing abnormality alone does not necessarily warrant dietary restrictions or food texture modifications. No interventions consistently prevent aspiration and no tests consistently predict who will develop aspiration pneumonia.



Altered Consistency Research Trends

Not all residents with dysphagia aspirate or choke and not all aspiration results in pneumonia. While a modified barium swallow may show that thickened liquids reduce the risk of aspiration acutely, there is little to no long term evidence that this intervention prevents aspiration pneumonia.



Altered Consistency Current Thinking

Often aspiration risks must be tolerated because of other, more immediate or probably risks such as nutrition or hydration deficits.



Tube Feeding



Tube Feeding AMDA

- Contrary to what people think, tube feeding does not ensure the patient's comfort or reduce suffering; it may cause diarrhea, abdominal pain, and local complications and may increase the risk of aspiration.



Tube Feeding Relevant Research

Studies in the elderly with dementia have shown

- Little to no improvement in weight
- No improvement in clinical outcome
- No impact on pressure ulcers or on infections such as cellulitis associated with wounds



Tube Feeding Recommended Course of Practice

- When there is weight loss and functional decline in an elder with multiple comorbidities or with end stage disease **the default should not be to place a g-tube for nutrition and hydration.** The interdisciplinary team including the elder's primary care physician should meet to address the elder's and or POA goals for care and develop a care plan that meets the changing needs of the elder. This may include a discussion regarding palliative care or hospice with the elder and the family.



Real Food First



Real Food First CMS

- With any nutrition program, improving intake via wholesome foods is generally preferable to adding nutritional supplements



Real Food First Relevant Research

... Offering residents a choice among a variety of foods and fluids twice per day may be a more effective nutrition intervention than oral liquid nutrition supplementation. Also found was that snack options are a more cost-effective nutrition intervention relative to supplementation based on staff time, resident refusal rates, caloric intake and waste.



Real Food First Recommended Course of Practice

- Advocate the use of **real food before supplements**.
- Recommend using **real food before any modified foods** including laxative mixtures or single source nutrient powders/liquids.
- Instead of art. supplements, extra protein, vitamin and fiber powders can be added to smoothies, shakes, malts **and other real foods people like to eat**.
- Use of **fresh produce is encouraged** i.e. from gardens.



Real Foods First Recommended Course of Practice

- The dining experience should be as natural as possible **comparable to eating at home**.
- **Resident satisfaction** with the quality of the food and the dining experience should be a home's priority.



Honoring Choices



Honoring Choices CMS

- F242 Self Determination and Participation
- F289 Participation in Planning Care and Treatment – The resident or representative has the right to make informed choices about accepting or declining care and treatment.



Honoring Choices Recommended Course of Action

- Choices with **meaningful options** in accordance with the person’s preferences are offered to each resident numerous times daily, i.e. when to awaken, when to eat, what to eat, where to eat, what to do, when to bathe, when to retire, what to wear, etc.
- **A variety and increased number of staff present in the dining room** enables both physical and psychosocial needs to be met. Additionally, staff can enhance and honor the individual choices for all residents reflective of preferences.



Honoring Choices Recommended Course of Action

- There needs to be a new **“red flag”** or “assumption” for both surveyors and providers that a **tray line or set/limited meal times are now viewed as an obvious contradiction of choice** and if this lack of choice leads to failure to thrive it would be considered harm during the survey process.
- **Residents’ individual choices are actively sought after, care planned and honored, as Tag F 242 requires**, based on life patterns, history and current preferences.



Honoring Choices
Recommended Course of Action

- Team members of all disciplines and MDS Coordinators identify in assessment and on care plans a person's **preferences more so than problems**, distinguishing between true medical problems and personal preferences using the new guidance at Tag 242 "actively seeking preferences" to guide all team members. Create a new standard of practice that care plans identify familiar and meaningful foods preferred.



Honoring Choices
Recommended Course of Action

- There needs to be another new **"red flag"** whereby any notation in a resident record or care plan of a resident as **"non-compliant" with physician orders is viewed as an obvious contradiction to resident choice** with a shift to facility non-compliance with requirements to offer choice at Tag 242, right to refuse treatment at Tag 155 and right to same rights as any citizen of the US at Tag 151.
- Instead of labeling one as "non-compliant," **nurses work with physicians to eliminate "orders" for restrictive diets residents don't eat** and instead create plans with the person that work for the person.



Honoring Choices
Recommended Course of Action

- When caring for frail elders there is often no clear right answer. Possible interventions often have the potential to both help and harm the elder. This is why the physician must be present [involved] in order to explain the risks and benefits to both the resident and IDT. The information should be discussed amongst the team and resident/family and only then should an agreed upon choice be made. **It is when the team makes decisions for the person without agreement by all that problems arise.** The agreed upon plan of care should then be monitored to make sure the community is best meeting the resident's needs.



Honoring Choices
Recommended Course of Action

- Provide education and support to anyone speaking on behalf of the resident, including health care professionals, families, friends, and legal representative on their obligation in **advocating for** the resident's/the person's individual life patterns, history, current preferences, opinions and wishes (**not necessarily their own**). Education should be inclusive so that the representatives clearly see their role as **an advocate for** the individual's choice (**not necessarily their own**).



Honoring Choices
Recommended Course of Action

- **We do not assume that just because a resident may not be able to make decisions in some parts of their life they cannot make choices related to their dining preferences.** Education, good observational skills, strong advocacy and consistent relationships with caregivers enables a person with impaired decision making capacity to make choices.



Honoring Choices
Recommended Course of Action

- When making dining decisions that can be viewed as a risk to the individual's physical health, the plan of care will be adjusted to **honor choice and provide the supports available to mitigate the risks** based upon the individual's life goals.
- **Put resident choice before regulations and guidelines such as Recommended Daily Allowances which are generic estimated nutritional needs and non-individualized.**



Honoring Choices Recommended Course of Action

- Resident **preferences in dining will be communicated to the entire interdisciplinary team** so that medications and treatments, schedules and food offered at activities are consistent with choices honoring personal preferences.
- Resident **dining profiles (tray tickets) should be limited to adapted equipment, allergies, consistency modification and unique dietary needs.** Preferences should be sought after as choices are offered (not just once and then recorded on a tray ticket indefinitely).



Definition from CMS

- The right to make informed decisions means that the patient or patient's representative **is given the information needed in order to make "informed" decisions regarding his/her care.**

CMS State Operations Manual Appendix A Hospitals Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, A-0049 482.13(b)(2).



Shifting Traditional Professional Control to Support of Self Directed Living



Shifting Control
Recommended Course of Action

- **All decisions default to the person.**



Changing Communities. Changing Lives.

Shifting Control CMS

- Residents have **the right to refuse treatment**, CMS Tag F155
- Residents have **the right to informed choice**, CMS Tag F325.
- Residents have **the right to choice**, CMS Tag F242.



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Shifting Control Current Thinking

- If the patient is sufficiently informed about the risks and benefits of acceptance (informed consent) or refusal (informed refusal) of a proposed intervention or treatment and refuses, **the clinician should respect the patient's decision** (Mayo Clinic Proceedings 2005).
- McMahon, MM, Hurley, DL, Kamath, PS, Mueller, PS. Medical and Ethical Aspects of Long-term Enteral Tube Feeding. *[Mayo Clinic Proceedings](#) Nov. 2005; 80(11): 1461-1476.



Changing Communities. Changing Lives.

Shifting Control - CMS

- CMS: Tag F325 Nutrition, Deficiency Categorization
- Severity Level 4 - **Immediate Jeopardy**:
Substantial and ongoing decline in food intake resulting in significant unplanned weight loss due to dietary restrictions or downgraded diet textures (e.g., mechanic soft, pureed) provided by the facility **against the resident's expressed preferences**.



Shifting Control - CMS

- Severity Level 3 - **Actual Harm**:
- Unplanned weight change and declining food and/or fluid intake due to the facility's failure to assess the relative benefits and risks of restricting or downgrading diet and food consistency or to obtain or **accommodate resident preferences** in accepting related risks;
- Decline in function related to poor food/fluid intake **due to the facility's failure to accommodate documented resident food dislikes and provide appropriate substitutes**.



Shifting Control – Current Thinking

- ... It is the dawning of a new day to realize there are **negative outcomes we are not considering and people's health and well-being are in the balance**. (Bowman, Background paper for CHII 2010).



New Negative Outcome AMDA



New Negative Outcome AMDA

- 'Person-directed care' is a philosophy that encourages both older adults and their caregivers to express choice and practice self-determination in meaningful ways at every level of daily life. Values that are essential to this philosophy include choice, dignity, respect, self-determination and purposeful living.



New Negative Outcome
Current Thinking

- The nursing process, which involves assessment, diagnosis of need, planning of care, implementation
- And evaluation of success of implemented care, supports honoring resident preferences and implementing dining practices that support choice.



**New Negative Outcome
Current Thinking**

- It is as difficult as staring straight at the sun, but if we as a profession are to initiate radical change, then we must be conscious of and focus on the harm that we do. Harm – not just to the body, but to the very person – is systematically embedded in bureaucratic institutions that strip elders of their personhood.

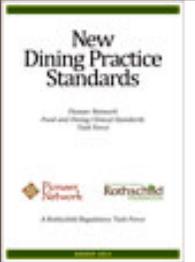


**New Negative Outcome
Recommended Course of Practice**

- All health care practitioners and care giving team members **offer choice in every interaction** even with persons with cognitive impairment in order to ensure control remains with the person, higher satisfaction with life, improved brain health and to prevent any harm from not honoring choice which has been proven to bring about earlier mortality.



- Supported by twelve professional organizations
- Used by nursing home profession
- Referred to by CMS




Essential Elements of Households

- 1. The household is each resident's home and sanctuary.
- 2. The people who live here direct their own lives, individually and collectively.
- 3. The boundaries of the person and his/her home are clear and respected as a matter of course.
- 4. Grace, a shared sense of what is sacred about the house and its people, is deeply valued, consciously created and preserved. Ritual, spontaneity, friendship, spirituality, celebration, recreation, choice, interdependence, art and humor are all manifestations of a culture of grace.



From *In Pursuit of the Sunbeam*
By Shields and Norton

Daily Pleasures with Food



Choice, Accessibility, Pleasure and Relationships





