

Connections

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IN THIS ISSUE

Chair Update	3
The Journey Worth Taking; <i>a Culture Change Experience</i>	6
NCP Corner	8
How to navigate the challenges and optimize your experience as a preceptor	11
Registered Dietitian Safety in Home Care	13
Hospice Corner - Geriatric Failure to Thrive	15
Raise Your Voices!	16
50 Years with ADA!	16
DHCC 2011 Award Recipients	17
National Pressure Ulcer Advisory Panel Update	18
2011 ADA Leadership Institute	19
LET'S KEEP IN TOUCH	20
Call For Authors	21



The New Dining Practice Standards Impacting Long-term Care

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Pioneer Network, an organization whose mission is to advocate and facilitate deep system change and transformation in our culture of aging by identifying and promoting transformations in practice, services, public policy, and research. Their vision is a culture of aging that is life affirming, satisfying, humane, and meaningful. Part of that vision is an in-depth change in systems requiring changes in governmental policy and regulation; changes in the individual's and society's attitudes toward aging and elders; changes in elders' attitudes towards themselves and their aging; and changes in the attitudes and behavior of caregivers toward those for whom they care. (pioneernetwork.net)

Pioneer Network in partnership with the Centers for Medicare & Medicaid Services (CMS) have been partnering in the culture change of long-term care facilities. Culture change is a transformation anchored in values and beliefs that return control to the elders and those who work closest with them. Culture change can transform a facility into a home; a resident into a person; and a schedule into a choice.

In 2008 CMS and Pioneer Network partnered in "Creating Home in the Nursing Home I: A National Symposium on Culture Change and the Environmental Requirements." (<http://pioneernetwork.net/Events/CreatingHomeI/>) The symposium featured national experts exploring the physical environment of the nursing home. The symposium was heralded as a success within the long-term care community and a second symposium was soon in the works, "Creating Home in the Nursing Home II: A National Symposium on the Food and Dining Requirements." This symposium was to bring together a diverse group of professionals exploring current dining practices and relaying evidence based practices supporting culture change in dining. The symposium was snowed out leaving over 1200 potential participants hungry for information. Refusing to be silenced by Mother Nature, Pioneer Network and CMS elected to offer the symposium on-line. (<http://pioneernetwork.net/Events/CreatingHomeOnline/>) The information remains available on-line today.

An Industry of Regulations

CMS regulations drive all systems within the long-term care facility; therefore any changes within the industry must start with regulation or interpretive guidance. Karen Schoeneman, Deputy Director of CMS Long-term Care Division (has since



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The New Dining Practice Standards Impacting Long-term Care

continued from page 1

stepped down) was a founding member of Pioneer Network. Her vision for person-centered care has significantly impacted the interpretive guidance we follow today. Her vision and intimate knowledge of the regulations lead to the New Dining Practice Standards, published September 2011 (<http://pioneernetwork.net/Providers/DiningPracticeStandards/>). It was her idea to develop a set of dining standards that were agreed upon by a majority of professional organizations representing clinical practitioners. Through a grant from the Hulda B & Maurice L Rothschild Foundation the Pioneer Network convened a meeting of stakeholders to review, amend, and agree upon a set of dining standards that would embrace current thinking and evidence based practices of person centered care. It was a brilliant move to secure the agreement of dining standards from a representative group of professional organizations. Why? There are a number of CMS regulations that specifically reference professional standards into which falls the New Dining Practice Standards.)

A. F281 Professional Standards. The facility must provide services that meet professional standards of quality – services that meet accepted standards of clinical practice published by a professional organization such organizations as American Dietetic Association, American Medical Directors Association, and so forth.

B. F492 Compliance With Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.

C. F501 Medical Director. The medical director is responsible for implementation of resident care policies and coordination of medical care. The Medical Director collaborates with facility leadership, staff, and consultants to develop, implement, and evaluate resident care policies and procedures that reflect current standards of practice. (https://www.cms.gov/manuals/downloads/som107ap_pp_guidelines_ltc.pdf)

These professional standards, approved by 12 professional organizations (text box), now have the full weight of CMS through interpretive guidance. In other words the long-

term care community has to sit up and take notice. In fact Alice Bonner PhD, Director Division of Nursing Homes, spoke to New York's Leading Age. In her presentation she stated, "CMS participated in the Food and Dining Clinical Task Force. Surveyor training is being developed on the new clinical practice standards. Surveyors will be evaluating the facility's efforts to establish the new standards." Now that we know CMS is serious about these standards let's take a look.

The New Dining Practice Standards

The document recommends ten new standards in dining supported by referenced citations from ADA, AMDA, and CMS.

- Individualized Nutrition Approaches/Diet Liberalization
- Individualized Diabetic/Calorie Controlled Diet
- Individualized Low Sodium Diet
- Individualized Cardiac Diet
- Individualized Altered Consistency Diet
- Individualized Tube Feeding
- Individualized Real Food First
- Individualized Honoring Choices
- Shifting Traditional Professional Control to Individualized Support of Self Directed Living
- New Negative Outcome

ADA's position paper, Individualized Nutrition Approaches for Older Adults in Health Care Communities (1) was referenced throughout the dining standards. It was particularly gratifying to see the word individualized in the standards, mirroring the title of our position paper. It is even more gratifying reading excerpts from our position

Professional Organizations

American Association for Long Term Care Nursing (AALTCN)
American Association of Nurse Assessment Coordination (AANAC)
American Dietetic Association (ADA)
American Medical Directors Association (AMDA)
American Occupational Therapy Association (AOTA)
American Society of Consultant Pharmacists (ASCP)
American Speech-Language-Hearing Association (ASHA)
Dietary Managers Association (DMA)
Gerontological Advanced Practice Nurses Association (GAPNA)
Hartford Institute for Geriatric Nursing (HIGN)
National Association of Nursing Administration in Long-term Care

The New Dining Practice Standards Impacting Long-term Care

continued from page 2

paper used to support the basic concepts of the New Dining Standards.

The New Dining Standards remind us that residents have the right to choose the type and amount of food served based on preference and informed choice. Resident selection may not always agree with practitioner, but which of us always makes the 'right' choice? "When educating residents keep in mind these are geriatric patients and the goal of care is to avoid consequences," states Jacki Lloyd, MD, Education Coordinator Geriatrics Department Florida State University College of Medicine. It is not okay to prescribe a restrictive diet that will result in negative outcomes secondary to the resident's refusal to eat.

Practitioners are encouraged to give residents the 'right to folly', exhibit poor judgment in choice. Key word is choice. CMS regulation F151, ADA Code of Ethics (2)), and American Dietetic Association Revised 2008 Standards of Practice for Registered Dietitians in Nutrition Care; Standards of Professional Performance for Registered Dietitians; Standards of Practice for Dietetic Technicians, Registered, in Nutrition Care; Standards of Professional Performance for Dietetic Technicians, Registered (3) in the extended care setting support the individual's right to choose, even if that choice is contradictory to evidence based practices. Furthermore a resident's choice cannot be categorized as non-compliant. The term non-compliant is going to become a red flag to surveyors signaling a lack of resident informed choice.

Teaching the resident about food selection that supports overall health is a vital role of the Registered Dietitian (RD). An important teaching tool will be the select menu or menu with alternates. This menu must offer usual and customary foods to the region and a selection of healthful foods so the resident has a true choice. For example, a Texan will probably never give up chicken fried steak with gravy, but may welcome a healthful alternative on occasion.

The interdisciplinary team (IDT), including the physician, plays a vital role in educating the resident and family of the risk/benefit of their choices. The New Standards support informed choice not only with therapeutic diets but also food/fluid consistency and tube feeding. Each resident has

the right to decide which is more important, quantity or quality of life. A regular diet with thin liquids may lead to aspiration pneumonia and untimely death, but some would argue enjoyment derived from savoring food/fluids far outweighs the risk. Who amongst us really wants to deprive the individual with end stage dementia the simple joy and comfort of a familiar food or beverage? ADA's position paper on end-of-life (4) states tube feeding does not prolong survival, improve function, prevent aspiration pneumonia, reduce the risk of pressure ulcers, or provide palliation for the individual with advanced dementia. (eatright.org)

When residents eat food they enjoy there is a decreased need for supplements. Too often the oral nutritional supplement is the first line of treatment for poor appetite or weight loss. The RD must evaluate assessment data and identify the root cause of the problem before recommending interventions. (5) Oral supplement may be the best choice in some cases, but not all. Keep in mind food quality may be the root cause and only through improved food service will resident outcomes improve.

Offering real food first, in the right size portion, has been associated with weight stabilization or weight gain. Real food first may inspire recipe enhancement; use current recipes as a foundation and add flavor enhancements for increased acceptance. Trained chefs have become more prevalent in long-term care facilities by offering knowledge in recipe development and food preparation. Quantity food production may take a backseat to a la carte menus offering resident point of service choice. RDs and Chefs truly working together may be the solution to real, flavorful food first.

Recommendations of the Food and Dining Clinical Standards Task Force

The final recommendations published in the New Dining Practice Standards include:

- *Diet is to be determined with the person and in accordance with his/her informed choices, goals, and preferences not exclusively by diagnosis.*
- *Assess the condition of the person using quality of life markers such as satisfaction with food, mealtime service, level of control, and independence.*
- *Assess and provide a resident's preferred mealtime routine and unique mealtime needs. These may include:*

The New Dining Practice Standards Impacting Long-term Care

continued from page 4

eating alone or with others; requiring assist with meal preparation, adaptive eating device, opening cartons, cutting food, adapted wheelchair placement; eating when hungry rather than at prescribed mealtimes or a person skipping breakfast may prefer an early lunch. Include quality of life markers such as satisfaction with food, meal service, level of independence and control.

- *Unless a medical condition warrants a restricted diet consider beginning with a regular diet and monitor tolerance.*
- *Empower and honor the person first and the IDT second when creating effective solutions.*
- *Support a self-directed, individualized plan of care.*
- *Ensure the physician and consultant pharmacist are aware of resident food and dining preferences so medication issues can be addressed and coordinated (e.g., medication timing and impact on diet/food intake).*
- *Monitor the person and his/her condition related to goals regarding nutritional status and their physical, mental and psychosocial well-being.*
- *Although a person may not be able to make decisions about certain aspects of their life, it does not mean they cannot make choices in dining.*
- *When a person makes a 'risky' decision the plan of care will be adjusted to honor informed choice and provide support to mitigate the risks.*
- *Most professional code of ethics require the professional to support the person in making their own decisions; being an active, non-passive participant in their care.*
- *All decisions default to the person.*

Every resident has the right to make informed decisions based on individual preferences and goals. One size does not fit all. As health care providers it becomes our job to ensure resident autonomy is supported by policy and practice. For example does every resident in the facility being treated with dialysis have a standardized renal diet order? What happens if the resident has a low potassium level? Does the RD intervene by educating the resident about foods rich in potassium and then offering the resident a choice in food or is a potassium supplement given while the diet stays the same? Does every person with diabetes have to be on a controlled carbohydrate diet planned by the RD or can some residents make their own food selections while maintaining acceptable blood glucose levels? Does every resident with dysphagia have to eat mechanically altered foods and drink thickened

liquids? When does quality of life trump evidence-based treatments?

Examine your answers to these questions. If your responses were aligned with provider knows best then consider becoming a student of the New Dining Standards, CMS regulations and the ADA publications cited in this article. As for the rest of you, one word best describes your elder's feelings - thankful.

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