

Person Centered Dining

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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. (<http://pioneernetwork.net>)

Pioneer Network in partnership with Centers for Medicare and 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. A set of research papers, accompanied by oral presentations, were commissioned by CMS from experts Carmen Bowman, Linda Bump, Linda Handy, Karyn Leible and Wayne Matthew, Denise Hyde, Robin Remsburg, Judah Ronch, and Sandra Simmons and Rosanna M Bertrand. 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.

These papers formed the basis for a stakeholder workshop held on May 14, 2010 that was attended by 83 national leaders. Recommendations from this workshop were to form a national stakeholder workgroup and develop agreed upon, evidence based, individualized standards.



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 (retired) 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. It was her idea to develop a set of dining standards that were agreed upon by a majority of professional organizations representing clinical practitioners in long-term care. 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

(https://www.cms.gov/manuals/downloads/som107ap_pp_guidelines_ltcf.pdf) that specifically reference professional standards into which falls the New Dining Practice Standards. (<http://pioneernetwork.net/Providers/DiningPracticeStandards/>)

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 [nka Academy of Nutrition and Dietetics], 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.*

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.

Professional Organizations

American Association for Long Term Care Nursing (AALTCN)
American Association of Nurse Assessment Coordination (AANAC)
American Dietetic Association (ADA) [Inka Academy of Nutrition and Dietetics]
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 (NADONA/LTC)
National Gerontological Nursing Association (NGNA)

The New Dining Practice Standards

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

1. Individualized Nutrition Approaches/Diet Liberalization
2. Individualized Diabetic/Calorie Controlled Diet
3. Individualized Low Sodium Diet
4. Individualized Cardiac Diet
5. Individualized Altered Consistency Diet
6. Individualized Tube Feeding
7. Individualized Real Food First
8. Individualized Honoring Choices
9. Shifting Traditional Professional Control to Individualized Support of Self Directed Living
10. New Negative Outcome

The Academy of Nutrition and Dietetics' position paper, *Individualized Nutrition Approaches for Older Adults in Health Care Communities*

(<http://www.eatright.org/About/Content.aspx?id=8373>) was referenced throughout the dining standards. For the RD it was affirming to read excerpts from the Academy's position 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 Jacqueline J 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, the Academy of Nutrition and Dietetics Code of Ethics

(<http://www.eatright.org/healthprofessionals/content.aspx?id=6868#.UJLdDO2trKY>),

and the Academy of Nutrition Dietetics Standards of Practice and Professional Performance of the Registered Dietitian Registered in Extended Care Settings

(<https://www.eatright.org/shop/product.aspx?id=6442468221>) 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 support 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? The Academy of Nutrition and Dietetics position paper on end-of-life 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. (<http://www.eatright.org/About/Content.aspx?id=8408>)

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.

(<http://www.eatright.org/healthProfessionals/content.aspx?id=7077#.UJLeh-2trKY>) 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.



Cultivating a Culture of Change

Change is not easy. This is demonstrated by each of us as we stick to our daily routine. In long-term care change is typically a result of survey non-compliance. There are innovative providers that look to the future and implement services that will be demanded by their clients, the baby boomers (the I want it all and I want it now generation). A good example, assisted living communities offering a more homelike environment accompanied by more independence than a traditional nursing home.

The administrator and/or owner of the facility must support the transformation of the facility's culture. Why? With any change there are bumps in the road that result in discouragement. Successful change mandates a leader to weather the storm and lead the staff to the desired destination.

Over 10 years ago Eli Pick, LNHA and (at the time) owner of Ballard Healthcare in Des Plaines, Illinois had a vision for culture change throughout the facility, including dining services. He rallied the management team in support of a dining experience that mirrored fine dining offered in the community. The vision for change was introduced to the direct care staff over dinner. The management team demonstrated the desired meal service by acting as wait staff. In the days that followed all department heads trained their staff and solicited recommendations after each meal. Staff embraced the challenge and ultimately developed successful systems for person centered dining unthought-of by management. Residents, without hesitation, voiced their preferences as well.

Facilities were amended; a laundry closet was transformed into a satellite kitchen housing a steam table, sink, and refrigerator. An electric warming cart transports food for each meal and a portable bus-station is set-up at the end of the hall for each meal's debris. Music is played at lunch and supper, but the morning news is broadcast at breakfast (resident choice). Residents make informed choices at meal times resulting in improved customer satisfaction and food consumption.

<http://www.youtube.com/watch?v=KWghsBG2fCM&feature=plcp>

Informed choice is achieved through education of the resident, family, and staff. The dogma of restrictive, therapeutic diets is counter to the person-centered model. Menu planning and medication provide the foundation to disease management in today's long-term care community. Resident preferences are honored, whether it is a restrictive choice or a liberal choice. Documentation of resident decisions in his/her plan of care must be noted and updated at least quarterly.

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: 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 requires 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 Academy of Nutrition and Dietetics publications cited in this article. As for the pioneers, one word best describes your elder's feelings - thankful.



Resources

1. Pioneer Network and Food and Dining Clinical Standards Task Force (2011) *New Dining Practice Standards*. Chicago. Retrieved from <http://www.pioneernetwork.net/Data/Documents/NewDiningPracticeStandards.pdf> Accessed 1 November 2012
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