NEW DINING PRACTICE STANDARDS
Excerpts from Pioneer Network
Food and Dining Clinical Standards Task Force
AUGUST 2011


The Task Force is comprised of symposium experts, representatives from Centers for Medicare & Medicaid Services Division of Nursing Homes, the US Food & Drug Administrators & the Centers for Disease Control & Prevention as well as the national standard setting groups.

A complete list of national organizations agreeing to the New Dining Practice Standards are listed on the published document of the Dining Practice Standards. Go to www.PioneerNetwork.net A partial list follows:
American Medical Directors Assoc.(AMDA), American Dietetic Assoc.(ADA), American Speech-Language-Hearing Assoc.(ASLHA), American Occupational Therapy Assoc. (AOTA) Dietary Managers Assoc.(DMA), National Assoc. of Directors of Nursing Administration in LTC (NADNA), National Gerontological Nursing Assoc.(NGNA)

DIET LIBERALIZATION
List of recommendations repeated for all therapeutic diets

- Diet is to be determined with person & in accordance to his/her informed choices, goals & preferences, not exclusively by diagnosis.
- Assess the condition of the person. Provide the person’s preferred environment for meals, i.e. meal times, routines for socialization during meals, food preferences, physical support, etc.
- Begin with Regular Diet unless medical condition warrants restriction & monitor how the person does with eating.
- Empower & honor the person first, support self-direction & individualize the plan of care.
- Ensure physician & pharmacist are aware of preferences so medication can be addressed & coordinated i.e. medication timing & impact on appetite.
- Monitor the person & their condition related to nutritional goals as well as their physical, mental & 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.
- When a person makes “risky” decisions, the plan of care will be adjusted to honor informed choice & provide supports available to mitigate the risks.
- Most professional codes of ethics require the professional to support the person/client in making their own decisions, being an active, not passive, participant in their care.
- All decisions default to the person.

LOW SODIUM: Recommended Course of Practice

1. 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 & therefore should only be used when benefit to the individual resident has been documented.

CARDIAC DIET: Recommended Course of Practice
1. Low saturated fat (low cholesterol) diets have only a modest effect on reducing blood cholesterol in the long term care elder population & therefore should only be used when benefit has been documented.

**INDIVIDUALIZED TUBE FEEDING: Recommended Course of Practice**

1. When there is weight loss & functional decline in an elder with multiple co morbidities or with end stage diseases the default should not be to place a g-tube for nutrition & hydration. The interdisciplinary team including the elder’s primary physician should meet to address the elder’s or POA goals for care & 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 & the family.

**INDIVIDUALIZED REAL FOOD FIRST: Recommended Course of Practice**

1. Advocate the use of real food before the addition of dietary supplements.
2. Recommend using real food before any modified foods including laxative mixtures or single source nutrient powders/liquids.
3. Instead of artificial supplements, extra protein, vitamin & fiber powders can be added to smoothies, shakes, malts & other real foods people like to eat.
4. Use of fresh produce is encouraged, an example would be produce from resident gardens.
5. The dining experience should be as natural as possible comparable to eating at home.
6. Resident satisfaction with the quality of the food & the dining experience should be a home’s priority.

**DIABETIC: Current thinking**

1. ADA states “there is no evidence to support prescribing diets such as no concentrated sweets for older adults living in health care communities.” A liberal diabetic diet restriction, (NCS) has not been shown to improve glycemic control in nursing home residents.
2. Allow as much freedom as possible, it may be more appropriate to liberalize the treatment goals or targets (i.e. Hemoglobin A1C or cholesterol), rather than add more medications.
3. AMDA recommends individualizing the treatment plan for the older adult population, based on a resident’s underlying medical condition & associated co-morbidities & has stated a target hemoglobin A1C between 7 & 8 is reasonable.
4. 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. Little evidence supports the use of sliding insulin as it is reactive in nature & fails to meet the physiologic needs of the person.

**ALTERED CONSISTENCY DIET: Research Trends**

1. The anticipated outcome of foods ground or pureed and liquids thickened, is to improve oral intake & a reduced risk of choking /aspirations. However, data on their effectiveness is inconsistent.
2. 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 (thickened liquids) prevents aspirations pneumonia.
3. Recent information also raises the concern that these at- risk residents become more at risk for dehydration & malnutrition caused by the unpalatable & visually unappealing modified dysphagia diets.
4. There is evidence that improved oral care can reduce the risk of developing aspiration pneumonia in the elderly. Oral care can impact clinical issues such as dehydration. Residents with swallowing problems may be able to have water throughout the day as long as good oral care is provided. (i.e. the Frazier protocol)
5. **There is evidence** that altered consistency diets may increase the risk of nutrition & hydration deficits. Thickened liquids & pureed foods are often poorly tolerated.

6. While there are no currently published studies that show that tube feeding prevents aspiration, one study found that orally fed patients with dysphagic disorders had significantly less aspiration than tube-fed patients.

### SHIFTING TRADITIONAL PROFESSIONAL CONTROL TO INDIVIDUALIZED SUPPORT OF SELF DIRECTED LIVING: Recommended Course of Practice

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

### NEW NEGATIVE OUTCOME: Recommended Course of Practice

1. All health care practitioners & 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 & to prevent any harm from not honoring choice which has been proven to bring about earlier mortality. CMS: 325 Nutrition, Deficiency Categorization - Severity Level 4 – Immediate Jeopardy if substantial & ongoing decline in food intake resulting in significant unplanned weight loss due to dietary restrictions or downgraded diet textures provided by the facility against the resident’s expressed preferences.

### INDIVIDUALIZED HONORING CHOICES: Recommended Course of Action

1. A variety & increased number of staff present in the dining room enables both physical & psychosocial needs to be met. Staff can enhance & honor individual choices, reflective of preferences. (when, what & where to eat) Residents’ individual choices are actively sought after, care planned & honored as Tag F 242 requires.
2. Create a new standard of practice that care plans identify familiar & meaningful foods preferred.
3. There needs to be a new “red flag” for both surveyors & providers that a tray line or set/limited meal times are not viewed as an obvious contradiction of choice & if this lack of choice leads to failure to thrive it would be considered harm during the survey process.
4. There needs to a 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 of facility non-compliance with requirements to offer choice at Tag 242, right to refuse treatment at Tag 155 & right to same rights as any citizen of the United States at Tag 151. (CHII Recommendation)
   - Instead of labeling one as “non-compliant”, nurses work with physicians to eliminate “orders” for restrictive diets residents don’t eat. Create plans with the resident that work for the resident.
5. 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 & provide the supports available to mitigate the risks based upon the individual’s life goals.
6. Put resident choice before regulations & guidelines such as Recommended Daily Allowances which are generic estimated nutritional needs & non-individualized. (CHII Recommendation)
7. Resident dining profiles (tray tickets) should be limited to adapted equipment, allergies, consistency modification & unique dietary needs. Preferences should be sought after as choices are offered (not just once & then recorded on a tray ticket indefinitely).

*(Regular diet is defined as what should be prepared & offered to meet nutritional needs in accordance with the current recommended dietary allowances of the Food & Nutrition Board of the National Research Council, National Academy of Sciences)*
Pioneer Network is pleased to announce that its Food and Dining Clinical Standards Task Force: A Rothschild Regulatory Task Force has finalized new Dining Practice Standards agreed to by the following twelve national clinical standard-setting associations:

- 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 Directors of Nursing Administration in Long Term Care (NADONA/LTC)
- National Gerontological Nursing Association (NGNA)

These nationally agreed upon new food and dining standards of practice support individualized care and self-directed living versus traditional diagnosis-focused treatment for people living in nursing homes. The document includes the following new Standards of Practice:

- 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

The New Dining Practice Standards document reflects evidence-based research available to-date as well as current thinking which is in some cases in advance of research - thus a Research Agenda also came out of this work and will be shared by Pioneer Network in the near future for anyone to refer to and consider.

The importance of these new agreed upon clinical standards cannot be overstated as food and dining are an integral part of individualized care and self-directed living for people living in nursing homes.

Pioneer Network will submit the new Dining Practice Standards to CMS, FDA, CDC and the long-term care community at large. It is anticipated that CMS will refer to these new agreed-upon standards of practice within long term care interpretive guidance where they fit as CMS usually refers to the current standards of practice set by the clinicians who work within the long term care field. It is the goal of the Task Force that surveyors, clinicians and interdisciplinary team members will put these new standards into practice in order to continue their efforts to improve quality of life for those living in nursing homes across the country.

*Pioneer Network expresses its sincere appreciation and gratitude to Rob Mayer of the Hulda B. and Maurice L. Rothschild Foundation for his continued support of these efforts*
Individualized Dining: New Standards of Practice
Tip Sheet for Individualizing Dining When Nutrition Affects Clinical Issues

1. **Be direct.** Fully explain clinical concerns. Fully listen to resident goals. Share the clinical situation, the standards of practice and knowledge about how to treat it. Then find out what matters to the resident. Give the resident time to think it over. *They told me the way things were going to be, and I told them the way things were going to be… I mulled over the two prospects and came to a happy medium.*

2. **Real Food First.** Use Dietary **Preferences** instead of Dietary **Supplements**. For needed nutrients, ask what foods a resident likes to eat, when. Serve accordingly.

3. **QC+QL= Better QC and QL.** Quality of Care interventions work best when they are applied to each person’s Quality of Life considerations and these become the methods for achieving the goals. Use residents’ goals, customary routines, and preferences to design your approaches:

<table>
<thead>
<tr>
<th>Quality of Care Medical Goal / Intervention</th>
<th>Quality of Life Considerations / Methods</th>
<th>Quality of Care and Quality of Life Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>High protein foods based on resident preference</td>
<td>Extra bacon and eggs, chocolate milk in fridge</td>
<td>Protein up, wound heals</td>
</tr>
</tbody>
</table>

4. **Promote Independent Exercise of Preferences.** Make preferences easy to honor, rather than making them a constant exception to the norm. Have chocolate milk in a fridge in her room so it’s there whenever she wants it. *Help her fulfill her choices.*

5. **Meet as a Team with Caregivers to Find Out What Will Work for Each Person.** Consistent, dedicated caregivers know residents’ favorite foods and how and when they like to eat them. Dietary staff makes those foods available at those times.

6. **Team Support.** When CNAs are unsure about a resident’s choice, they can better support a resident’s choice the better they are supported by the nurse. When nurses are accessible for in the moment check-in’s, CNAs then have more confidence to accommodate residents’ choices.

7. **Use Organizational Practices That Rely on Knowledge of Dedicated CNAs.** Use consistent staffing, include CNAs in care planning, have good communication across the care team – CNAs with nurses, dietary staff, social worker, and therapy.

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**F281 STANDARD OF CARE**

(3) The services provided or arranged by the facility must--
(i) Meet professional standards of quality &; Intent §483.20(k)(3)(i):
The intent of this regulation is to assure that services being provided meet professional standards of quality, in accordance with a specific definition . . .
Dining Culture Change Resources

The New Dining Practice Standards Aug. 2011, http://pioneernetwork.net/Providers/DiningPracticeStandards/

Creating Home II CMS/Pioneer Network National Symposium on Culture Change and the Food and Dining Requirements, background and speaker papers (free) and webinars (nominal cost):

- Bowman, Carmen. The Food and Dining Side of the Culture Change Movement: Identifying Barriers and Potential Solutions to furthering Innovation in Nursing Homes, Background Paper written under contract with CMS.
- Leible, Karyn and Wayne, Matthew. The Role of the Physician’s Order.
- Handy, Linda. Survey Interpretation of Regulations.
- Hyde, Denise. The Role of the Pharmacist.
- Remsburg, Robin. Home-style Dining Interventions in Nursing Homes: Implications for Practice.
- Simmons, Sandra F., Bertrand, Rosanna M. Enhancing the Quality of Nursing Home Dining Assistance: New Regulations and Practice Implications.

www.pioneernetwork.net/Events/CreatingHomeII/

2007 CMS Four Part Webcast Series Clinical Case Studies in Culture Change


AMDA resources: The Role of the Medical Director in Person Directed Care white paper March 2010 (free) also Clinical Practice Guidelines (CPGs, member and nonmember prices)
www.amda.com

Individualized Nutrition Approaches for Older Adults in Health Care Communities


Promising Practices in Dining – www.pioneernetwork.net/PromisingPractices/

Design on a Dollar – regarding dining areas – www.pioneernetwork.net/Providers/DOD


Life Happens in the Kitchen all day workshop offered by Action Pact
events.r20.constantcontact.com/register/event?llr=aienv5bab&oecd=a07e38xr00qb24c4408

Nourish the Body and Soul workbook and training DVD, http://culturechangenow.com/kit-nbs.html

Dining with Friends 20 min. video https://www.arc-ct.org/dining_with_friends_overview.php
Dining Culture Change Resources


Person Directed Dining Package downloadable “lessons learned,” new policies and procedures - http://calculturechange.com/CultureChangeInCalifornia/Programs.aspx#pcdp


Planetree and Picker Long-Term Care Improvement Guide http://www.residentcenteredcare.org/ Part Three: Practical Approaches for Building a Resident-Centered Culture, Culinary Engagement

Change Ideas Worksheets – The Dining Experience, Quality Partners of Rhode Island http://www.qualitypartnersri.org/2/Site/CustomFiles/Qtly_DocMgr/IndividualizedCare-Dining.pdf


*The Handy Method for QAPI in Establishing Outcome Oriented, Resident Centered Nutrition and Dining in Nursing Homes and Culture Change in Dining and Regulatory Compliance, Linda Handy www.eihnet.com/handy

*Living Life to the Fullest: A Match Made in OBRA '87; Regulatory Support for Culture Change; Changing the Culture of Care Planning; Vibrant Living: Quality of Life: The Differences between Deficient, Common and Culture Change Practice; SOFTEN the Assessment Process, authored or coauthored by C. Bowman, www.actionpact.com/catalog/webstore; Workbooks and Kits and Packs

Conversations with Carmen, monthly culture change web talk show, www.actionpact/calendar

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