Liberalized Diets: What Do You Mean We are Going to "Let" Them Eat "Real" Food?

Honoring Choice and Protecting Your License Go Hand in Hand

Session Objectives

- Analyze the "speech therapy routine" approach to swallowing difficulties
- Explore how the regulations and multiple professional organizations support the liberalization of diets in long term care
- Discover how Evergreen Community of Johnson County liberalized diets and the outcomes that occurred

Presenters

- Karen Craig RN-C
  GERTI Instructor
  karenc@gerti.org
- Chris Osborn RN, MBA
  Chief Operating Officer
  chriso@eliinc.org

Importance

- "Meals are the single most consistently accessible, manageable, and effective health-promoting activity that we can offer to residents”
  Zgola & Bordillon, 2001

Recent Research Shows:

- 50%-70% of residents leave 25% or more of their food uneaten at most meals and both chart documentation of % eaten and the MDS are an inaccurate gross under estimate of low intake
- 60%-80% of residents have a physician or dietitian order to receive dietary supplements
- 25% of residents experienced weight loss when research staff conducted standardized weighing procedures over time

Malnourishment

- 23-85% of all residents in nursing homes are malnourished
- 54% of all new residents are malnourished
- 60% of new residents have an initial weight loss after they move in
- People who lose 5% of their body weight in one month were found to be 4 x more likely to die within one year!

ADA Position Paper 2005
The System is Not Working

- Elderly people with unintentional weight loss are at higher risk for:
  - Infection
  - Depression
  - Death

- The leading cause of involuntary weight loss is depression for people who live in long term care.

- What contributes to depression? A loss of control, a loss of purpose, a loss of self.

What Matters Most

- Creating an environment and a culture that returns
  - Autonomy
  - Dignity
  - Control
to the people who live in your community.

What is Your Dining Services System?

- Limited/set meal times
- Dining room is off limits to residents except at meals
- Snacks sent out from the main kitchen at 2p and 7p
- Main kitchen locked when the last dietary aide goes home
- Choice consists on 1 of 2 entrée choices
- Ice water is at every bedside
- Menus are determined by the RD and/or corporation

Dining Practice Standards Since 2011

- Choice - ask and honor choice
- Accessibility – food available 24/7
- Individualization – what warms the heart & soul
- Liberalized diets – improves intake
- Food first – food before supplements
- Quality service – relationships improve care
- Responsiveness – attention vs. "monitoring"

"At its best food nourishes us – body and soul. A meal can embody powerful symbols of love and acceptance. The bond between comfort and food, which begins at the breast, is fortified throughout childhood and gains renewed strength in the late decades of life. Properly prepared, the meals we cook and serve to our elders should be drenched in memory, ritual and culture. ... Fresh, local ingredients prepared according to authentic regional recipes are served to people eager to share. They use smell, taste and texture as a springboard to good conversation and vital relationships."

Dr. William Thomas, Eden Alternative Founder (2008)

True Choice, Not Token Choice or Point of Service Choice

- Choice of beverages
- Choice of breads
- Choice of desserts
- Choice of service style, whether waited on, self-selected, buffet or family
- What to eat
- When to eat
- Where to eat
- Who to eat with
- How leisurely to eat
Styles of Dining that are Working

- Buffet dining
- Restaurant style
- Family style
- "Room Service"
- 4 meals a day:
  - 7:30 am - continental breakfast in room
  - 10:30 am - main meal of the day
  - 4:00 pm - dinner
  - 7:30 pm - twilight meal

Accessibility

- Foods of choice available when hungry, or when just longing for a specific food.
- Food available 24 hours/day, 7 days a week, and someone available 24/7 to help prepare it.
- Refrigerator rights, perhaps even a refrigerator in their own room, and perhaps a microwave too!

Individualization

- The person’s favorite foods, comfort foods, or ethnic foods
- Foods prepared from their own favorite recipes
- Foods they choose to eat in their own home
- Foods that make them look forward to the day
- Foods that warm their heart and soul, as well as nourish their bodies

Caution!

- Potential "red flags":
  - Any notation in the record of care plan of a resident as "non-compliant" with a physician’s order should be viewed as an obvious contradiction to resident choice
  - Surveyors should consider the provider is "non-compliant" with the requirements at F442 (choice) and F393 (right to refuse treatment).

Risk and Culture Change

"An institution that focuses only on physical harm does great violence to that person, to their personhood, it violates the expressed preferences of the person... We all must guard against the unspoken contract that the more care and support you need, the more autonomy you must surrender."

Dr. Bill Thomas

Liberalized Diets

It is the individual’s right to choose if they wish to follow a restrictive diet.
What is Liberalizing a Diet?

- Lifting the restrictions of a therapeutic diet

"Healthcare professionals must understand that liberalizing the diet prescription... does not represent a disregard of the person's health, but is an appropriate reason for the shift in health care priorities."

Academy of Nutrition and Dietetics (aka ADA)

Who Supports Liberal Diets?

- Academy of Nutrition & Dietetics (previously American Dietetics Association):
  "Quality of life and nutritional status of older residents in long-term care facilities may be enhanced by liberalization of the diet prescription."

- American Diabetes Association:
  "The imposition of dietary restriction on elderly resident with diabetes in long-term health facilities is not warranted."

- American Medical Directors Association:
  Prevent unintended weight loss by "focusing on individualizing each resident's nutritional management."

- And the Biggie: CMS!

Organizations Agreeing to the New Dining Practice Standards

- American Association for LTC Nursing
- American Association of Nurse Assessment Coordinators
- Academy of Nutrition and Dietetics
- American Medical Directors Association
- American OT Association
- American Society of Consultant Pharmacists
- American Speech-Language-Hearing Association
- Dietary Managers Association
- Gerontological Advanced Practice Nurses Association
- Hartford Institute for Geriatric Nursing
- National Assoc. of Directors of Nursing Administration in LTC
- National Gerontological Nursing Association

F325 - Nutrition

- The facility must ensure that a resident maintains acceptable parameters of nutritional status...
  - Receives a therapeutic diet when there is a nutritional problem.

Intent of F325 (per 9/1/08 revision)

- Must provide nutritional care and services to each resident
- Must recognize, evaluate and address needs of every resident
- Provide a therapeutic diet that takes into account the clinical condition, and preferences, when there is a nutritional indication.
Research suggests that a liberalized diet can enhance the quality of life and nutritional status of older adults in long-term care facilities.

Dietary restrictions, therapeutic (e.g., low fat or sodium restricted) diets, 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.

From Federal Regulation F325:

AMDA Clinical Practice Guidelines

“Routine dietary restrictions are usually unnecessary and can be counter-productive in the long term care setting. Special diets for diabetes, hypertension, heart failure, and hypercholesterolemia have not been shown to improve control or affect symptoms.

When a patient is at risk for or has an unintended weight loss, the presence of one of these diagnoses alone is insufficient justification for continuing dietary restrictions.”

From Academy of Nutrition and Dietetics (aka American Dietetic Association)

“...it is appropriate to serve residents with diabetes the regular (unrestricted) menus, with consistent amounts of carbohydrate at meals and snacks.

Foods should not be restricted to control blood glucose levels because of the risk of malnutrition. Regular menus in long-term care facilities generally are consistent in calories, are served at consistent times and contain small portions of food. If desserts are served, the portions are usually small.”

From ADA’s “Diabetes Care”

“Meal plans such as no concentrated sweets, no added sugar, low sugar, and calorie restrictive diabetic diets are no longer appropriate.

These diets do not reflect diabetes nutrition recommendations and unnecessarily restrict sucrose.”

More from the ADA - continued

From the Federal Regulations

• Research has indicated that restrictive diets are not particularly beneficial to the health or well-being of seniors living in long-term care

• Dignity and quality of life become issues when restricted in community living setting
“Individualized Plan”
- The resident’s preferences must be on the care plan and
  - Include resident's likes
  - Include resident's dislikes
  - Preferences
- Can use the RAI as a guideline for discovering a person's choices

Section F of MDS 3.0:
Customary Routine
- “How important is it to you to have snacks available between meals?”
- How about these questions:
  - “Your doctor has recommended a restrictive diet. Is this something you want
to do?”
  - “Your doctor has ordered thickened liquids because you have choked before.
Is this alright with you?”

Therapeutic Diets
- a diet ordered by a physician as a part of treatment for a
disease or clinical condition, or to increase or decrease
specific nutrients in the diet, or to provide food the resident
is able to eat

Mechanically Altered Diet
- one in which the texture of the diet is altered. When the
texture is modified, the type of texture modification must
be specific and part of the physician's order.

But, the “State” Said
- No federal regulation requiring a physician’s order for a regular diet!
- No state regulation requiring a physician’s order for a regular diet!

“Someday, we will get to the place where a physician’s order is merely a
recommendation.”
Karen Schoeneman,
Retired Deputy Division Director for
the Nursing Homes Division, CMS
Words Matter

**Let**
- to give opportunity to or fail to prevent
- used as an auxiliary to express a warning ("let him try")
- to permit to enter, pass, or leave

**Allow**
- to permit (something); to regard or treat (something) as acceptable
- to permit (someone) to have or do something
- to permit (someone) to go or come in, out, etc.

The Pureed Diet “Routine”

1. Staff observe resident choking – tells nurse
2. Nurse contacts physician
3. Physician orders swallow study
4. Swallow study shows potential for aspiration pneumonia – refer to SLP
5. SLP orders pureed diet

NO ONE asks the resident!!!!!!

Chewing and Swallowing per CMS

- “It is essential to take a holistic approach and look beyond the symptoms to the underlying causes”
- “Excessive modification of food and fluid consistency may unnecessarily decrease quality of life and impair nutritional status by affecting appetite and reducing intake”

CMS on Aspiration Pneumonia

- “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.”

Instead of Pureed, How About...

- Treating medical conditions that can impair swallowing such as:
  - GERD
  - Oral or dental problems
  - Impaired saliva production
- Evaluating medications that cause dry mouth or coughing

Medications that May Cause Anorexia or Weight Loss

- Aricept
- Depakote
- Duragesic patch
- Effexor
- Many cardiac drugs
- Most antibiotics
- Neurontin
- Risperdal
- Wellbutrin
- Zoloft
- Anticholinergic drugs d/t mouth dryness
Before Pureed:

- Ensure proper positioning for eating
  - 90° in a dining room chair
- Participation in a restorative dining program
- Use of assistive devices/utensils
- Prompt assistance during every meal and snack
  - Supervision, cuing, hand-over-hand

Upgrading a Diet

- Improves intake
- Minimizes struggles over dietary compliance (resident, staff, and family)
- Improves quality of life

Meal Percentages

- Not required per regulations
- Not necessary to be done on everyone
- Consider doing only for the few who are at risk or have significant weight loss
- Type of food consumed is as important as the overall %
- Consider supplementing if intake <50%

Restorative Dining

- Residents are not “feeders” they are people who need assistance with nutrition/eating/dining
- Sit at table in same manner as everyone else – in dining room chair
- Serve with respect, dignity and interpersonal attention

Sudden Decline in Eating

- Someone needs to look in the person’s mouth: ill fitting dentures, broken teeth, cavities
- Re-evaluate medications which can sometimes affect the appetite:
  - constipation
  - changes in taste (we lose half our taste buds by 80!)
  - dry mouth can reduce the desire to eat.
Dining Environment

- One of the most important things we do for our elders is provide nutritional, appetizing food.
- The environment must be conducive to conversation and socialization.

What if...?

- Condiments (salt & pepper, sugar, ketchup, hot sauce, etc.) were on the table?
- Cream was in a pitcher vs. creamer packet?
- Butter was in a stick or tub?
- Plates were garnished with a lettuce leaf, a sliced peach or spiced apple ring?
- People sat in dining room chairs?
- Linen table cloths and napkins vs. bare tables and bibs?

What if...

- Soft music played?
- Seasonal centerpieces made by the people who live there?
- Displays of entrees and desserts?
- No meds in dining room?
- No tray service?

Food First

- Choosing food before supplements and food before medication is a natural decision in culture change.
- The need for costly, and often refused, commercial supplements is eliminated.
- The need for laxatives is reduced and often eliminated with increased fluid intake and increased opportunities for fiber rich, bowel-stimulating foods of choice.
- Even the need for medication for behavioral management can be reduced when foods of choice are available at times and places of choice.

Food Fortification

- Adding protein, fat, and/or carbohydrate to foods such as: hot cereal, mashed potatoes, casseroles, desserts.

NOTE: heavy cream has 52 cals/Tblsp.

8 Ounce High Calorie Milk Shake vs. Ensure

Milk shake = 400-500 calories  Ensure = 220 - 350 calories

Which one would you prefer?
Real Food Examples

Milkshake Recipe
- ½ cup vanilla ice cream (130 kcal, 2 gm protein)
- ½ cup heavy whipping cream (240 kcal, 3 gm protein)
- 2 Tbsp chocolate or strawberry syrup (optional, 100 kcal)
- 2 Tbsp whipped topping (25 kcal)

Blend or briskly stir together heavy cream and ice cream.
Mix in syrup. Pipe on whipped topping. Total: 400–500 kcal, 5 gm protein

Fortified Hot Cocoa Recipe
- 1 packet hot cocoa mix (80 kcal)
- ⅛ cup heavy whipping cream (120 kcal)
- ¾ cup half & half (240 kcal)
- 1 ounce (⅛ cup) miniature marshmallows (20 kcal)

Pour packet into microwavable mug, add cream and half and half. Microwave for 1–1 ½ minutes. Stir, add marshmallows. Total: 460 kcal

Quality Service

- Relationship-based service is caregiving from the heart.
- Knowing the person, their choices, their preferences, and their daily pleasures in dining, results in service that encourages optimal intake.
- Knowing what a person ate, knowing what they need to eat, knowing what to tempt them with, all can make the difference between joy in dining and failure to thrive.
- Comes from consistent staffing

Practices that Improve Quality Service

- Staff dining with the people who live there:
  - Creates a more “normal” social environment
  - Creates a greater sense of family by increasing meaningful conversation
  - Improves intake
  - A nice thing to do for your staff
- Giving people foods that give them comfort

Proven Benefits, No Matter the Style

- Decreased waste
- Reduced/eliminated supplement costs
- Decreased medication costs
- Improved clinical outcomes

NOTE: be sure to collect baseline data before implementing any changes so you can measure results.

Bump, 2004

Common Barriers

- Resistance from:
  - Physician
  - Dietitian
  - Nurse
  - Family
  - Surveyor

NOTE who is NOT on this list: resident!

Challenges for the Nurse

- Afraid you will lose your license?
- Why?

Let’s talk through it: your state’s Nurse Practice Act requires you to:
  - Perform services under the direction of a person licensed to practice medicine (follow physician’s orders)
  - Take appropriate action or to follow policies and procedures in the practice situation designed to safeguard each person
- So, what to do?????
Overcoming Barriers

- Education is the key:
  - Medical Director prn and then move on to other physicians
  - Inform them of the professional organizations (including AMDA) who support it
  - Residents in the community & families
  - Evidence based dining standards
  - How food choices can affect health
  - Nursing staff and surveyors
  - Nurses may need help in "dealing with" a person with diabetes eating real cake

Getting Started

- Implement a liberal diet policy and procedure
  - Enlist the help of Medical Director and RD
  - New residents will be on regular diet and current residents will have a diet conversion if that is approved by them
  - Ongoing monitoring to ensure that changes are happening
  - Deal with problems on a case-by-case basis

Sample Policy Statement

"Nutrition is an important part of the physical, emotional, and social well being of residents at Evergreen Community. We follow the positions, practice guidelines, and recommendations of the American Diabetic Assoc. and the American Gastroenteric Association, and other health care professionals in their recommended policies and practices as they relate to seniors and Long Term Care residents.

When appropriate, we provide medical nutrition therapy based on individual needs and monitor the nutritional health of all our residents.

A restrictive diet is not appropriate if it infringes on the quality of life or otherwise undermines one's overall physical well being. When possible, we recommend non-dietary approaches for the treatment of diabetes, and other diseases. We recommend or encourage restrictive diets only on an individual basis, and only after reviewing all the circumstances and options."

What We Have Heard

- "Management won't let us"
- "This too will pass."
- "It's too much work."
- "No one wants to."
- "It will cost too much."
- "Why bother?"
- "Our residents are satisfied."
- "The surveyors will cite us."

The Battle of Resistance

- "But we have always done it this way!"
  - Task & time less defined
  - Threatens authority/license
  - Titles, roles, and routines change
  - Staff thinks it is a 'fad' and will go away
  - OMG, someone might choke!

A Philosophical Shift

- People don't live where we work....
- We work where people live! In their homes!
- When you change your thinking from a "facility" to a 'home', things you have done in the past become unthinkable:
  - Rearranging a room due to falling
  - Rummaging through drawers for lost items
  - Changing rooms to be closer to the front
  - Telling your host what they can and cannot eat
  - Barging through the door without waiting to be asked to enter . . .
The Evergreen Journey

Maya Angelou said:

“If you don’t like something, change it. If you can’t change it, change your attitude.”

“If I had known better, I would have done better.”

Well, we know better now...

Discussion