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Caring for the Ages

A Monthly Newspaper for Long-Term Care Practitioners

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Freedom of Choice: Updated Dining Practice Standards Call for Diet Liberalization

BY LINDA HANDY, MS, RD

Nursing facility staffs across the country are on a challenging journey to improve their residents' dining experience while ensuring compliance with regulatory requirements. The true stories of two residents illustrate different tactics to approaching residents' rights to eat what they want.

The first resident, Mr. C, wanted non-pureed foods and his favorite thin liquids after he was assessed by a speech language pathologist (SLP), who determined he needed a pureed diet with nectar-thick liquid. Staff informed the resident and documented the risk/benefit. The resident's preferences and choices were incorporated into his plan of care, and the facility arranged a negotiated risk agreement with him. Facility staff continued to monitor Mr. C and offered alternatives, which he accepted and rejected as he defined his own quality of life.

The second resident, Mrs. A, had been encouraged by staff to accept a tube feeding status, but she repeatedly asked if she could dine on pureed food with her long-time companions. The facility leadership was surprised when given the F 151 deficiency for not informing Mrs. A of her rights. They shouldn't have been.

Respecting residents' diet preferences is becoming standard procedure in post-acute/long-term care. An article in *Mayo Clinic Proceedings* provides thorough guidance to a patient's right to eat the way they want (*Mayo Clin Proc* 2005;80:1461-76). In a case example, the authors wrote: "The patient expressed a desire to eat small amounts of food, despite the risk of aspiration. It is ethically and legally permissible for patients with decision-making capacity to refuse unwanted medical interventions and to ignore recommendations of the clinician. … [A] patient's choice not to adhere to a clinician's recommendations may be at odds with a clinician's desire to 'do good' or avoid harm. If the patient is sufficiently informed about the risks and benefits of … [informed] refusal of a proposed intervention or treatment and refuses, the clinician should respect the patient's decision."

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Not respecting a resident's dietary preferences may put your facility in the surveyor's crosshairs.

Creating Ten Standards

Shortly after I retired as a dietitian specialty surveyor, I was asked to participate

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Dextromethorphan/Quinidine Effective for Agitation

BY MITCHEL L. ZOLER

WASHINGTON — Daily treatment with a combined formulation of dextromethorphan and quinidine led to a significant and clinically meaningful decrease in agitation episodes among patients with Alzheimer's disease in a controlled, phase II, 10-week study with 159 patients.

The combined, oral formulation was generally well tolerated, without appearing to cause somnolence or cognitive decline, Jeffrey L. Cummings, MD, ScD, reported at the Alzheimer's Association International Conference 2015.

A treatment that cuts the frequency and severity of agitation in Alzheimer's disease patients would be very helpful as this is "one of the most difficult symptoms for patients. [Agitation] makes it very difficult to care for a family member with Alzheimer's disease," said Dr. Cummings, professor of neurology at the Cleveland Clinic and director of the clinic's Lou Ruvo Center for Brain Health in Las Vegas.

"Agitation is one of the most disturbing and disabling symptoms associated with Alzheimer's disease," commented Mary Sano, PhD, professor of psychiatry and director of Alzheimer's disease research at Mount Sinai Hospital in New York. "Movement on treating this symptom has the potential to make a real difference

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Freedom of Choice

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on a National Symposium Task Force, partnering the Pioneer Network with the Centers for Medicare & Medicaid Services. At the time, many facilities were having difficulties complying with two separate and distinct sets of regulations.

The first, or the "care" regulations (requiring the best evidence-based and clinical expertise), said facilities must:

- ▶ Determine and offer care for assessed needs.
- ▶ Follow physician's diet orders and regularly scheduled dining times.
- ▶ Ensure residents are safe from negative outcomes such as choking, aspiration pneumonia, and high blood glucose.

The other "rights" regulations stipulated that facilities must:

- ▶ Allow the resident the right to decline medical therapy.
- ▶ Respect the quality of life decisions of residents.
- ▶ Provide reasonable accommodation for dining place and time.

The "care" and "rights" regulations were often at odds with each other, and facilities were concerned about receiving a deficiency practice citation if they respected rights and failed to deliver or ensure that care needs were met (see "Survey Interpretation of Regulations" at www.pioneernetwork.net/Data/Documents/CreatingHomeOnline/Paper-Handy.pdf).

The task force was fortunate to have two medical directors who were actively involved in AMDA: Matthew Wayne, MD, CMD, chief medical officer, Summa Physicians and New Health Collaborative, Summa Health System, in northeast Ohio, and Karyn Leible, MD, CMD, geriatrician, Centura Health, Westminster, CO. Their paper, entitled "The Role of the Physician's Order," contained a concise recommendation list at the end that would become the basis of ten dining practice standards (www.pioneernetwork.net/Data/Documents/CreatingHomeOnline/Paper-WayneandLeible.pdf). The task force emphasized the removal of negative terms such as "noncompliant" or "refuses" from care planning and encouraged respectful terms such as "honoring" resident choice and preferences.

Although it is not a simple, clear cut process, the facility staff has a responsibility to "assess and offer" appropriate, individualized care needs. This is followed by discussion and documentation with the resident (or surrogate decision maker on behalf of the resident), to determine his or her desires and identify the potential outcomes. The ten Dining Practice Standards (DPS), approved by 12 national organizations (including AMDA), was issued in August 2011 by the Pioneer Network (www.pioneernetwork.net/Providers/DiningPracticeStandards), to guide staff in making the best decisions for their residents. These are:

- ▶ 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 first standard, Individualized Nutrition Approaches/ Diet Liberalization, includes the following statement from AMDA: "Weight loss is common in the nursing home and associated with poor clinical outcomes such as the development of pressure ulcers, increased risk of infection, functional decline, cognitive decline and increased risk of death. One of frequent causes of weight loss in the long-term care 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. Swallowing abnormalities are common, but do not necessarily require modified diet and fluid textures, especially if these restrictions adversely affect food and fluid intake."

Each dining practice standard concludes that all decisions are to default to the resident. One unique standard is the "New Negative Outcome," based upon a paper by Judah Ronch, PhD, entitled, "Dining, Memory and Aging: Food for Thought." In it, he uses the term "surplus safety," which means "conditions that prevent autonomous thinking or action and the satisfaction that decision-making brings because of an exaggerated fear that harm will come to the elder. This prevents the consequent cognitive, motor, emotional or other adaptive growth and development that would result if novelty had been pursued. Surplus safety assumes that the person will not be able to recover from the error or restore homeostatic balance if she makes a bad choice, and further that an elder does not have the developmental readiness to take the risk that the novel stimulus presents and to learn from the experience" (https://www.pioneernetwork.net/Data/Documents/CreatingHomeOnline/Paper-Ronch.pdf).

The survey process evaluates how the facility staff prevents physical negative outcomes (weight loss, skin breakdown, labs that are not within normal limits). How will this new negative outcome standard be evaluated? It may be helpful to ask the following questions:

Real food options, including high calorie/high protein choices, are preferred over supplementation.

- ▶ Will residents be informed and feel empowered to partner with facility staff in making quality of life dining decisions?
- ▶ Are facility staff members steadfast in old practices and reluctant to allow residents to make decisions that would put them at risk?
- ▶ Are attending physicians liberalizing diets that come from hospital transfer orders based on diagnosis?
- ▶ Are diet orders customized according to the resident's wishes (e.g., "regular diet with sugar-free desserts and sugar substitute" instead of "carbohydrate controlled" or "diabetic," and "regular diet with no-salt packet and low potassium foods of resident choice" instead of "renal diet")?

Implementing Choice on Record

Customizing and individualizing diets according to a resident's wishes has become the standard for one of the largest nursing home groups in the country, and facilities in the group now embrace the new dining practice standards. This group has determined that only one diet can be checked off on the diet list, which has invited liberalization and thoughtful change in the ordering of diets. Originally this determination was a reaction to deficiencies being given when dietary staff could not produce and have on the tray line all the restricted items of multiple diet orders, and could not follow multiple columns on tray lines from the "modified" menu.

The "one diet" concept means one column to follow for tray line or when serving in the dining room. The diet that is checked off may be a regular diet or a texture-modified or puree diet. Then the customized diet adds a drop down menu in the PointClickCare electronic health record, with specifics aimed at individual patient requirements and portion size. When the diet list is printed as a reference to nurses and activities staff, it includes all the specifics for each individual resident.

When the Resident Arrives

The process of developing an appropriate diet starts with the resident's admission to the nursing home. One of the first staff interactions for a new resident is held with the dietary manager, who usually prescreens the

PA/LTC Perspective

This is an interesting article, remarking on the ongoing tension between fear of survey deficiencies and respect for resident rights, with unwritten references to today's hot topics of patient-centered care, quality of life and goals of care. The link is how an involved medical director can think outside the box to directly improve resident satisfaction.

And this isn't even about any specific medical issue — we're talkin' food here! Food, universally acknowledged as one of the most important aspects of resident quality of life across the spectrum of post-acute/long-term care. The concept of liberalization of diet is long-recognized, both for resident satisfaction and lowering error rates in facilities. It's unfortunate that the Dining Practice Standards approved in 2011 have not achieved as much traction as one might have hoped, despite the involvement of two esteemed AMDA past-presidents Karyn Leible, MD, CMD, and Matthew Wayne, MD, CMD.

There are certainly barriers in the area of ordering diets and using best practices in this arena:

- ▶ Physicians don't regard this as a "medical" issue.
- ▶ Speech language pathologist evaluations don't always correlate clinically (we have all seen residents made NPO who are able to eat without apparent difficulty).
- ▶ An unpalatable therapeutic diet can be under-recognized as a cause of weight loss.
- ▶ Sodium restriction has become more of a knee-jerk order as congestive heart failure protocols become increasingly common, based on lowering hospital readmission rates (arguably based on financial imperatives, not resident wishes).
- ▶ Frequently, attending physicians do not change any admission orders from the hospital, including the diet — in fact, the type of diet is commonly not even mentioned or looked at by health care providers.

Unfortunately, achieving the "right" diet for a resident can turn into a no-win situation for the facility. Giving a less restrictive diet means a resident's medical concerns are not addressed, while a more restrictive diet runs counter to the resident's wishes — in either case, leading to a survey deficiency. Education, communication, and documentation (the holy triad of good medical care) are essential here. Although other members of the interdisciplinary team are crucial in establishing best practices for diet liberalization, the medical director can provide assistance, support, and current references to help champion this cause, as well as provide leadership through the use of the QAPI process.

—Daniel Haimowitz, MD, FACP, CMD
Levittown, PA

patient for traditional dietary preferences, allergies, intolerances, and preferred location of dining (i.e., in room or dining room). Many dietary managers are expanding this initial interview with questions about the resident's diet preferences and when the resident

The nursing home should have clearly defined procedures for ensuring that there is follow-up documentation, education of risk/benefit, and alternatives offered by the physician, dietitian, and speech language pathologist.

normally eats (i.e., late breakfast, snacking throughout the day, late evening snack). New residents are informed that they may sleep in and have a right to a reasonable accommodation of a late breakfast and food opportunities throughout the day, as close to their usual home-like pattern as possible.

Dietary managers use this prescreening opportunity to inform new residents about their dining rights by using open-ended questions, such as "Do you want to follow the ordered diet?" or "Do you know that you have a right to decide what diet is best for you?" When the resident does not want to follow the ordered diet, the first step is to try to get the order liberalized to honor the resident's choice. The nursing home should have clearly defined procedures for ensuring that there is follow-up documentation, education of risk/benefit, and alternatives offered by the physician, dietitian (for therapeutic diets), and speech language pathologist (for texture modified diets and thickened liquid restrictions.) Facilities can develop detailed negotiated risk agreements when high-risk diet items are provided to honor the resident's choice.

Other concerns that may be addressed during the prescreening of the resident include:

▶ Are the residents who are NPO (tube feed) also informed of their rights? Does the facility staff offer oral gratification of food with sips of water coupled with effective oral hygiene programs, such as the Frazier Free Water Protocol, which is defined in Pioneer Network's "Dining Standards Toolkit" (see "Ensuring Quality With Dining Standards Toolkit")?

▶ When nutrition interventions are required, are real food options, fortification programs, and high-protein/high-calorie snacks of choice emphasized vs. health shakes and supplements?

▶ Is the TwoCal Med Pass (60 cc or 120 cc of high calorie/protein supplement) considered for extra nutrition without diminishing the resident's appetite?

▶ Are creative hydration stations/carts and snack carts being implemented?

High Calorie/High Protein Needs

When a high-risk resident requires an increase in calories/protein, the attending physician, dietitian, and dietary manager should collaborate to implement the standard of "Real Food First." Does the dietitian make recommendations to the attending physician to obtain orders for fortified real food commercial products (e.g., Magic Cup Frozen Dessert, Home Care Nutrition, Hormel Health Labs) or for a planned "fortified diet" using specific fortification recipes for hot

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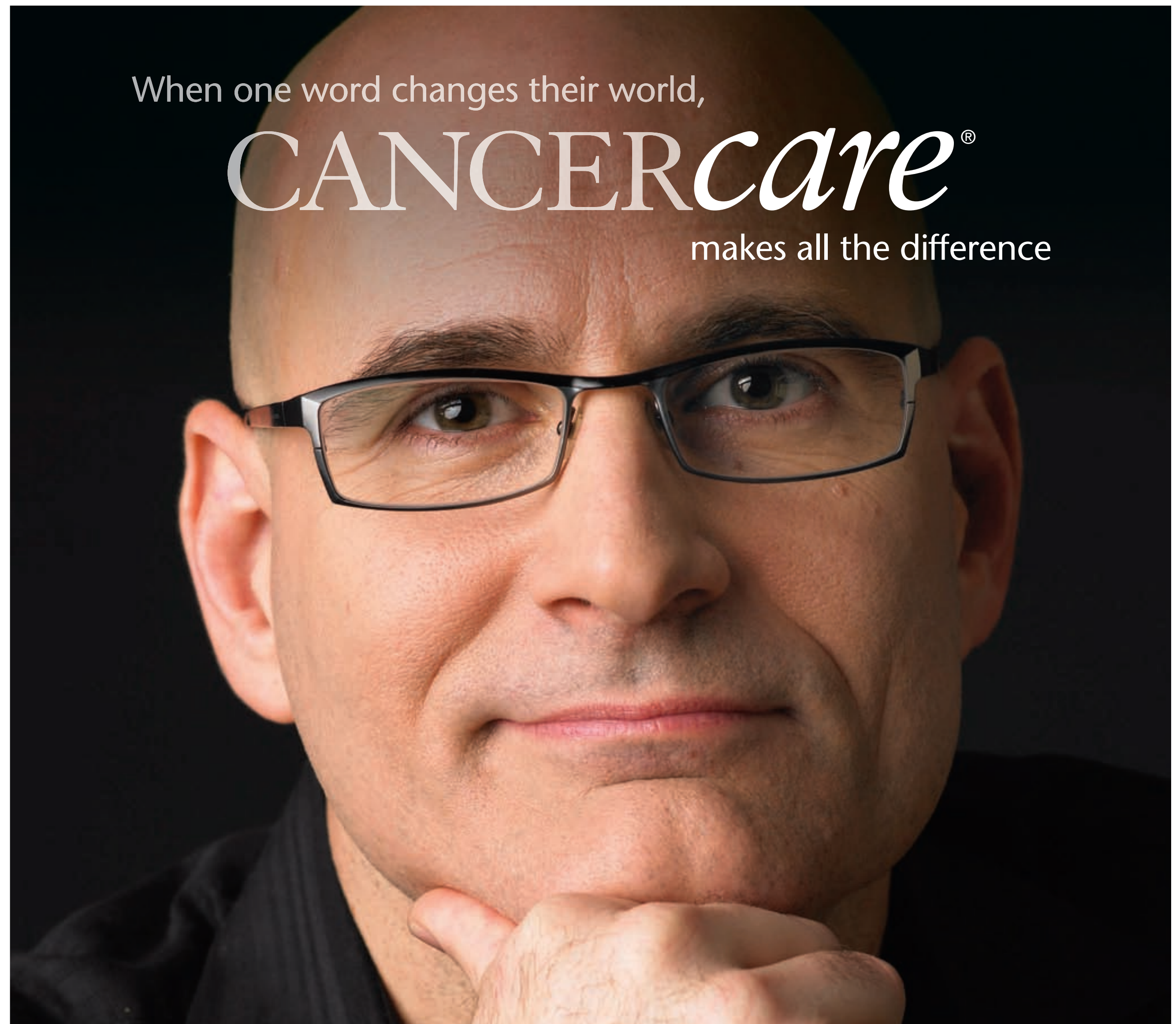
For More Information

The Centers for Medicare & Medicaid Services announced surveyor training on the DPS and stated, "Research has indicated that many older individuals may not need to be limited to very restrictive diets, pureed foods, and thickened liquids even though they may have many chronic conditions. Conversely, restricting food choices can result in loss of appetite and eventual weight loss." For more information, see www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-13.pdf; and http://surveyortraining.cms.hhs.gov/pubs/VideoInformation.aspx?id=1101&cid=0CMSNEWDINPRSTAN.



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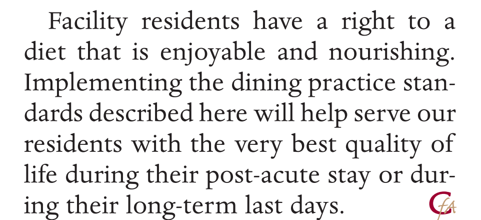
super cereal, soup, cheesy mash potatoes, or pudding, based upon resident preferences? Are cook staff trained to follow fortification recipes as ordered? This diet can provide 3000 calories/100 g protein daily if fortified items are consumed. Often the most at-risk resident is overwhelmed by a standard full meal and wants a small portion, so a fortified small portion ensures that every bite counts. Fortified small portions also reduce the plate waste/cost (feeding the garbage can) so prevalent in nursing homes.

Often residents come with established eating patterns of five or six small meals a day, which is now being implemented by some nursing homes. Diet orders can effectively redistribute the daily food allowance. Some have diet orders for a "fortified small portion" with high calories/protein snacks of choice between meals (cheese sticks, yogurt, peanut butter and crackers, fortified pudding, half a sandwich, fortified cookies and milk) vs. health shakes and supplements. Sometimes supplements may be necessary, such as when a resident will not eat but will drink; however, these should be ordered as the last resort.

Finally, adequate documentation of the additional calories/protein offered should be provided by the dietitian so that attending physicians and surveyors are able to follow up on how planned interventions are being accepted by the patient, and how they are meeting assessed nutrition needs. Constant monitoring is important. If the interventions are not being consumed, then consider trying new interventions.

Facility residents have a right to a diet that is enjoyable and nourishing. Implementing the dining practice standards described here will help serve our residents with the very best quality of life during their post-acute stay or during their long-term last days.



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Ensuring Quality With Dining Standards Toolkit

The Pioneer Network issued a Dining Standards Toolkit in 2014, which can be found on the Pioneer Network website. The toolkit serves to "help communities and care teams in decision making to support individual choice and also mitigate risks that may arise due to honoring choice." It includes references to CMS regulations and interpretive guidance, demonstrating CMS support in enabling individuals to eat their preferred foods. It includes model policies and procedures, tip sheets, benchmark templating, resources, and printable brochures for residents and family (www.pioneernetwork.net/Store/DiningStandardsToolkit).

One of the reference documents in the toolkit is this author's presentation at Pioneer Network's annual conference on August 14, 2013, entitled "Applying CMS Mandated QAPI 5 Elements to Ensure the New Dining Practice Standards [DPR], Resident Rights, and Resident Performance Improvement Leaders" (www.cms.gov/SurveyCertificationGenInfo/Downloads/fiveelementsqapi.pdf). The presentation was based upon Deming's "Performance Improvement Method: Plan, Do, Study, Act" (www.ihi.org/knowledge/Pages/HowtoImprove/default.aspx). Highlights from this method include:

The Plan: Evaluate the regulatory requirements and standards of practice for liberalizing or eliminating resident diets when a resident refuses nutrition medical therapy (therapeutic or texture modified diet orders). Evaluate the facility's current practices compared to the regulatory requirements.

The Do: Develop and approve new protocols for staff to inform residents of their dietary rights, ensure staff training, and ensure appropriate documentation according to new protocols.

The Study: Monitor staff with audits to determine if the new protocols are followed.

The Act: Evaluate staff compliance to regulatory requirements and new approved protocols. Provide corrective actions when approved protocols are not followed, with additional training to meet and sustain goal thresholds.

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Eligibility criteria and application materials are available at www.amdafoundation.org.