Learning Objectives

1. Understand CMS’ New Dining Practice Standards
2. Understand the role of the Diet Manual, Diet Orders, Menus and Disaster Planning in Health Facilities

3. Understand the Regulatory Role of the RD in Dietetic Services
4. Quality assurance performance improvement in Long term care and Hospitals

Dining Practice Standards Background

- In 2010, Pioneer Network/CMS Symposium, Creating Home in the Nursing Home II – A National Symposium on Culture Change and the Food and Dining Requirements.
- In 2011, an interdisciplinary task force was formed
- The Pioneer Network Food and Dining Clinical Standards Task Force, “Included 12 organizations representing clinical professions involved in developing diet orders and providing food service (including physicians, nurses, occupational and physical therapists, pharmacists, dietitians)
- Also participating were CMS, the Food and Drug Administration (FDA) and the Centers for Disease Control (CDC).”
Dining Practice Standards
Background
- The task force was created to establish "nationally agreed upon new standards of practice supporting individualized care and self-directed living versus traditional diagnosis-focused treatment."

Organizations Agreeing to the New Dining Practice Standards
- 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)

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

Diet Liberalization
- Our professional association, Academy of Nutrition and Dietetics came out with a position paper on diet liberalization in 2010.
- Be open-minded when assessing risk versus benefit of therapeutic diets for the frail older adults
- An unacceptable or unpalatable diet can lead to poor food and fluid intake, resulting in weight loss and under nutrition and a spiral of negative health effects
- Collaboration between resident, facility and practitioner to identify alternatives to restrictive diets when resident declines medically relevant dietary restrictions

Diabetic/Calorie Controlled Diet
- A consistent carbohydrate diet has been shown to be more effective than the regular diabetic diet in the elderly (AMDA)
- No concentrated sweets / No added sugar added no longer considered appropriate in the elderly (AND)

Low Sodium Diet
- May be beneficial to some, but more lenient blood sugar and blood pressure in the elderly is desirable. (AMDA)
- The relationship between CHF, BP and sodium intake not well studied. Liberal approach to sodium diet in the frail older adults may be needed to maintain nutritional status. (AND)
- When intake is poor IDT may temporarily abate nutritional restrictions to improve nutritional status (CMS)
Altered Consistency Diets
- Swallowing abnormalities do not necessarily require modified diet and fluid texture modifications (AMDA)
- The RD needs to collaborate with the SLP and/other health professionals to ensure that the older adult receives appropriate modified texture diets (AND)
- Holistic approach is necessary to determine course of action. No one intervention consistently prevents aspiration and no test consistently predicts who will get aspiration pneumonia. (CMS)

Tube Feeding
- Tube feeding may be clinically appropriate in certain instances but should not be an automatic step when other feeding strategies have failed (AMDA)
- Enteral nutrition may not be appropriate for terminally ill older adults with advance disease states, such as terminal dementia. (AND)
- Look beyond symptoms to determine plan of care (CMS)

Real Food First
- Provide foods of a consistency and texture that allow comfortable chewing and swallowing (AMDA)
- Food service goal should be meals that are natural and independent as possible making choices from a wide range of menu items with input from residents, families and staff. (AND)
- Improving nutritional status with wholesome food is preferable to nutritional supplements (CMS)

Honoring Choices
- Identify proper balance between medications, modifications and restrictions and allowing for personal choices is the essence of good medicine approach. (AMDA)
- Involve individuals about food and dining choices such as food selections, dining locations, meal times. (AND)
- There are regulatory requirements to ensuring that resident exercises rights and able to make choices ex. F242, F280

New Negative Outcome
- Person-directed care, choice and dignity, respect and self-determination and purposeful living are examples of values that are the core of desirable medical care. But current treatment practices may be in conflict with these values in the long–term setting. (AMDA)

New Negative Outcome
- For many older adults residing in health care communities, the benefits of lean restrictive diets outweigh the risks. Ask questions such as is it necessary will it offer enough benefits to justify its use? (AND)
New Negative Outcome

- CMS SOM –F325 Nutrition
  - Severity Level 4 Immediate Jeopardy e.g. Mechanically altered diets provided against the resident’s expressed wishes resulting in significant and unplanned weight loss.
  - Severity Level 3– Actual Harm– weight loss due to lack of assessment of risk vs benefit of restriction or down grading diet and food consistency or accommodate preferences in accepting related risks.

New Course of Action

- New way of thinking
  - Traditional Professional Control to Individual support of Self Directed Living
  - We are partners, consultants, educators’ professionals
  - Develop new approaches that reflects the view that the elderly are able to make choices about dining
  - Develop care plans from the problem approach to the choice or preference approach.

Summary

- The New Dining Standards a different mind set that would take a lot of imagination, creativity and ability to think “outside the box”
- Change in food service administration and application of MNT as we now know it.
- Change in our role as professionals.
- Educate yourselves.
- In the end, it will have a positive impact on the residents.

All Facilities Letter 14–32

Diet Manuals, Orders, Menus and Disaster Planning in Health Facilities

Link for All Facilities Letters

- [http://www.cdph.ca.gov/certlic/facilities/Pages/LnCAFL.aspx](http://www.cdph.ca.gov/certlic/facilities/Pages/LnCAFL.aspx)
- You can search by topic for all the State issued AFLs

All Facilities Letter 14–32

- New All Facilities Letter (AFL)
  - Diet Manuals, Orders, Menus, and Disaster Menu Planning Must Meet Patient’s Nutritional Needs
  - Supersedes the AFL 13–11
All Facilities Letter 14–32

Changes include
- The addition of Chemical Dependency Recovery Hospitals
- All reference to Dietary Reference Intakes (DRIs) and Adequate Intakes (AIs) have been removed

All Facilities Letter 14–32

What did not Change
- Diet Manual includes:
  • Purpose & principles of each diet
  • Nutritional adequacy & inadequacy
  • Foods allowed & not allowed
  • Sample meal patterns

All Facilities Letter 14–32

What did not Change
- Diet Manual should mirror the nutrition care provided by the facility

All Facilities Letter 14–32

What did not Change
- Nutrition Analysis of Menus
  • Assures nutrition needs are met
  • In accordance to physician orders
  • In accordance with RDAs

Survey & Certification Letter 15–22

From CMS, S&C 15–22
- Outlines revised guidance and regulations for HOSPITALS

Additional information:
§428.28(b) Menus must meet the needs of the patients (A–629)

HOSPITAL REGULATIONS

(1) Individualized patient nutritional needs must be met in accordance with recognized dietary practices

All Facilities Letter 14–32

- What did not change
  - Disaster Planning: food & water
  - Must have a detailed written plan
  - Consideration for the special needs of facility’s population

Disaster Planning

CMS created several recommended voluntary emergency preparedness tools to assist health care providers in their planning efforts

Dietary Staffing:
The RDs Role in Dietary Services

CMS’s Survey & Certification Emergency Preparedness Tools
**Dietary Staffing**

- Code of Federal Regulations
  - §482.28(a)(2) Hospitals
  - §483.35(a) SNFs
- CA H&SC 1265.4

**Dietary Staffing**

- The RD must be Full Time, Part Time or on a Consultant basis
- If the RD is not FT, there must be a FT Qualified Dietary Services Supervisor (DSS)

**Dietary Staffing**

- The DSS shall receive FREQUENTLY scheduled consultation from a qualified dietitian

**Dietary Staffing**

- §483.35(a) Skilled Nursing
  - Intent:
    - To ensure that a qualified dietitian is utilized in planning, managing and implementing dietary services

**Dietary Staffing**

- §483.35(a) Skilled Nursing
  - Intent:
    - The DSS and RD must function collaboratively to meet the nutritional needs of the residents

**Dietary Staffing**

- In Title 22 §70275(a) Hospitals
  - PT or Consultant RD shall be on the premises at appropriate times on a regularly scheduled basis and of sufficient duration to provide:
    - Guidance to the supervisor & staff of the dietetic services
All Roads Lead to...

RD’s Role In Dietary Service
- Assuring Safe Food Handling
- Assuring Sanitary Conditions
- Developing & Approving Menus
- Dietary Staff Development

QAPI
- Quality Assurance and Performance Improvement

QAPI
- A systemic, comprehensive, data-driven, proactive approach to improving the quality of life, care and services in health care facility
  - For all departments facility wide.

- Both hospital and Long Term Care have regulations for QAPI programs
Quality Assessment/Performance Improvement

- Should comprehensively reflect the operations of both foodservice and nutrition care
- Generally day to day monitoring activities would not meet the parameters of an effective QA/PI Program

QAPI Programs:

- Improving plate appeal for non select cycle menu
- Diabetic Patient ordered diets meet carbohydrate requirement
- Admission nursing screening parameters are effective

Quality Assessment/Performance Improvement

- Keeping hot food hot and cold food cold
- Meal ticket design on tray line efficiency and accuracy
- Improve appearance and consistency of pureed foods.

QAPI Programs:

- Improving plate appeal for non select cycle menu
- Diabetic Patient ordered diets meet carbohydrate requirement
- Admission nursing screening parameters are effective

Quality Assessment/Performance Improvement

The CoP of QA/PI requires that all departments develop a plan that demonstrates the implementation and maintenance of an effective, ongoing, data driven program that reflects the complexity of dietetic service

Roles of the RD

- QAPI
- P&T Committee
- Hospital-wide Practices R/T Nutrition
- Patient Rounds
- Disaster Preparedness
- Physician Orientation
- Nursing Orientation
- Patient Safety
- Wound care Committee
- RD

QA/PI Pitfalls

- Plan is limited to elements that the department does well
- No annual evaluation of the effectiveness of the QA/PI Plan
- Data collection elements remain the same from year to year
- QA/PI solely derived from patient satisfaction surveys and hospital compare data
QA/PI Pitfalls

- Contracted Vendors
- Clinical data is based solely on policies being followed rather than effectiveness of the service

CMS Resources

- Quality Net  
  [https://qualitynet.org/]

Quality topics

- Institute for Health Care Improvement (IHI):  
  [http://www.ihi.org]
- Advancing Excellence in America's Nursing Homes:  
  [http://www.nhqualitycampaign.org/]

CDA April 2015