Pioneer Network Dining Standards Summary

Pioneer Network announced 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 Food and Dining Clinical Standards Task Force made a significant effort to obtain evidence and thus the New Dining Practice Standards document reflects evidence-based research available to-date. This 62 page document’s main points which support SuzyQ cart System philosophy of self-determination are as follows;

http://www.pioneernetwork.net/Providers/DiningPracticeStandards/

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

12 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)

It is all of our jobs is to reduce loneliness, helplessness, and boredom (the major plague in LTC). Research proves this, and self-directed living is the key to allow a resident to decide if/what/when they want their life to look like when living in a Home (clothing, activities, meals, sleeping, when to wake up, bathing, etc).
BACKGROUND

CMS notes that the most frequent questions and concerns received by their staff focus on the physical environment and dining/food policies in nursing homes. A National symposium brought together a wide diversity of stakeholders, including nursing home staff, regulators, provider leadership, researchers, registered dietitians, vendors, and advocates for culture change, and was a two-year project.

We know that food & dining are an integral part of individualized care and self-directed living for several reasons:

✓ the complexity of food and dining requirements when advancing models of culture change
✓ the importance of food and dining as a significant element of daily living
✓ the most frequent questions and concerns CMS receives from regulators and providers consistently focus on dining and food policies in nursing homes.

Therefore, we believe this area is one most in need of national dialogue if we are to improve quality of life for persons living in nursing homes while maintaining safety and quality of care.

RESEARCH

“Person-directed care” is a philosophy that encourages both older adults and their caregivers to express choice and practice self-determination in meaningful ways at every level of daily life. Values that are essential to this philosophy include choice, dignity, respect, self-determination and purposeful living. These values also are at the core of desirable medical care and are embraced by many medical providers. Yet practices that conflict with these principles are common in the LTC setting. Page 47

It has been found that most residents with evidence of malnutrition were on restricted diets that might discourage nutrient intake (ADA position paper Liberalization of Diet improves quality of life in LTC)

Choice of food has a tremendous impact on quality of life. Some might say it defines quality of life (109)

Simply speaking, it is all about choice. It is as simple as asking “what does the resident want? How did they do it at home? How can we do it here? True choice, not token choice. For dining, true choice is exemplified in point of service choice…

Develop approaches to dining that reflect a view of elders as capable of making choices and deciding what, when, and with whom to dine as a mental wellness activity because it “exercises” the decision making circuitry of the brain, enhances pleasure and strengthens memory encoding and retrieval. (Food for Thought paper for CHII)

The majority of nursing home residents are able to reliably answer questions about their satisfaction with the food service, regardless of cognitive status, and the presence of complaints is related to poor meal intake and depressive symptoms (112)

As a team, need to develop a system promoting resident choice while maintaining quality of care. There needs to be a new “red flag” or “assumption” for both surveyors and providers that a trayline or set/limited meals are now viewed as an obvious contradiction of choice, and if this lack of choice leads to failure to thrive it would be considered harm during the survey process (CHII recommendation) – page 41

We do not assume that just because a resident may not be able to make decisions in some parts of their life, they cannot make choices related to their dining preferences. Education, good observational skills, strong advocacy and consistent relationships with caregivers enables a person with impaired decision making capacity to make choices. Page 42
Anyone speaking on behalf of the resident, including health care professionals, families and friends needs to be educated that they see their role as an advocate for the individual’s choice (not necessarily their own). 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, and provide the supports available to mitigate the risks based upon the individual’s life goals. Page 42

Resident dining profiles should be limited to adapted equipment, allergies, consistency modification and unique dietary needs. Preferences should be sought after as choices are offered (not just once and then recorded on a sheet indefinitely). Page 43

ADA – Despite the growing body of evidence discouraging the use of therapeutic diets in older adults, these diets are still regularly prescribed. Research has not demonstrated benefits of restricting sodium, cholesterol, fat and carbohydrate in older adults (121). Page 44

Caregivers often fear that resident’s mealtime choices will result in negative outcomes. Mealtime dining studies provide evidence that enabling residents to choose what they want to eat at mealtime does not result in negative nutritional outcomes. Enabling choice can increase nutritional intake and increase resident family and caregiver satisfaction (133, 134). Page 48

We all need to shift to agreeing that care givers will offer to do what is clinically best for a person, and if the person refuses that’s okay. Along with liability comes responsibility to the person we’re serving – if an elder decides to not eat what is clinically best we work with them but never force them – caring for someone doesn’t mean you have to make the choices for them (CHII recommendation). Page 45

Another level of education is needed for clinicians and care givers to be able to shift traditional professional control over to the resident since it feels like we’re going against what we have believed to be our obligation or even a nursing license to what “good care” is which we now realize has been making decisions for residents and not honoring their decisions (CHII recommendation). Page 46

Life goals should supersede medical best practices. Recommendations should be based on what each elder wants, not what we would want for ourselves or what we think the elder wants (125). Page 46

Residents who receive good personalized care and opportunities for choice have higher morale, greater life satisfaction and better adjustment (Institute of Medicine 145). Page 51

The dining experience should be as natural as possible comparable to eating at home. Resident satisfaction with the quality of the food and the dining experience should be a home’s priority. Page 34

Bulk food service and a home-like environment optimize energy intake individuals at high risk for malnutrition, particularly those with low body mass index and cognitive impairment (102). Page 37

Persons with mild to moderate cognitive impairment (ie mini mental exam scores 13-26) are able to respond consistently to questions about preferences, choices and their own involvement in decisions about daily living, and to provide accurate and reliable responses to questions. (105). Page 37

Dr. William Thomas (Eden Alternative founder) states; “I’m a firm believer in the rights of elders to do whatever the hell they want. If you only have the right to make a good, wise decisions that your grown daughter agree with, then you’re not running your own life anymore. I’ve taken care of lots of people who didn’t even know their own children. Sure, they probably shouldn’t be making decisions about their 401 plans, but they can decide what to wear, and what to eat and whether to go outside on a daily basis. People think that if old people cannot make the big decisions, they cannot make any decisions – and that is just wrong. They have the right to folly. (117). Page 41
All health care practitioners and 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 and to prevent any harm from not honoring choice which has been proven to bring about earlier mortality.

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