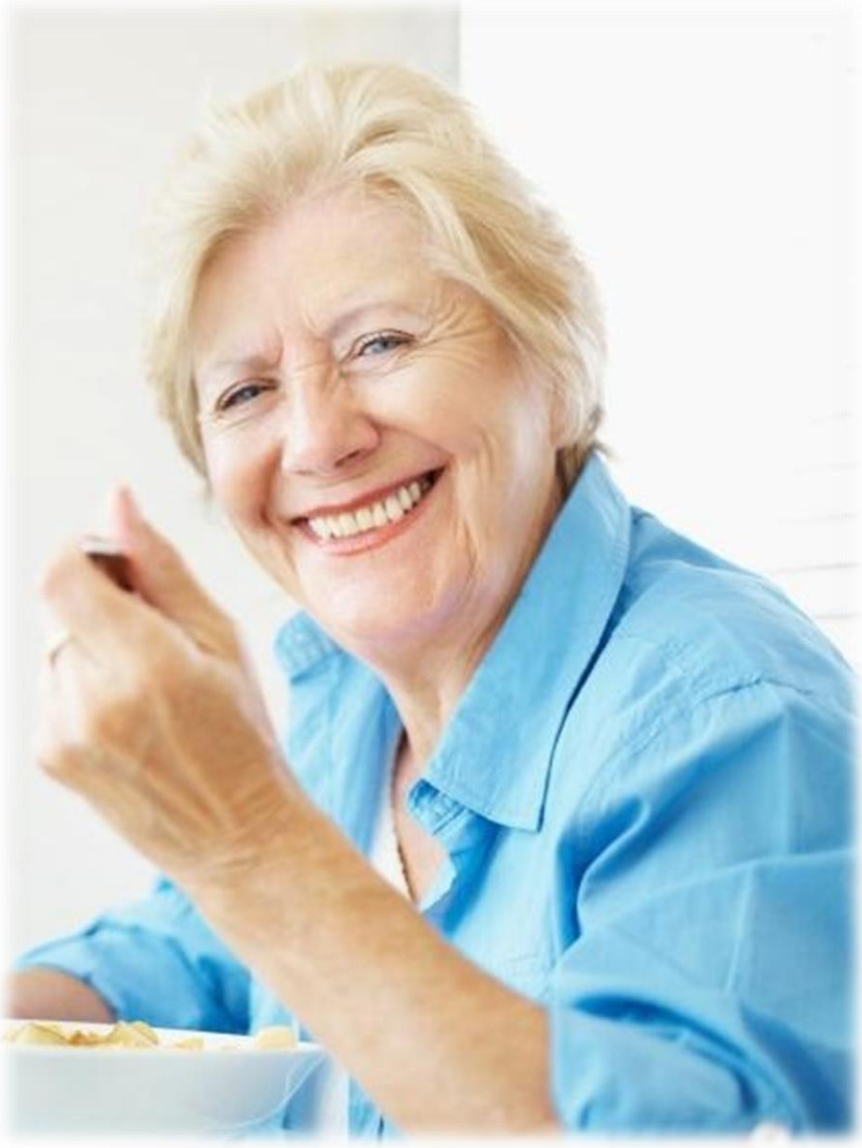
Making Mealtime Magic
With Person Centered Dining



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Acknowledgements

Author/Editor:
Becky Dorner, RDN, LD, FAND is widely-known as one of the nation's leading experts on nutrition, aging, and long-term care. An experienced speaker and extensively published author, Becky is Founder/ President of Nutrition Consulting Services, Inc., whose dedicated team of RDNs and NDTRs have served health care facilities in Ohio since 1983 and currently provide food and nutrition services to approximately 100 health care facilities in two states; and Becky Dorner & Associates, Inc., which provides a broad library of credible continuing education (CE) programs and nutrition resources.

Becky's mission to improve nutrition care for older adults has inspired her to present more than 500 programs for national, international and state professional meetings in 5 countries and 50 states; host more than 140 national professional CE webinars and teleseminars since 2004; and to publish more than 300 nationally/internationally recognized health care articles, manuals and CE programs including menus/recipes, clinical manuals, self-study CE programs, inservices, and publications primarily for health professionals working with older adults. Her free email magazine keeps 35,000 health care professionals up to date on the latest news in the field.

Becky has been an active leader holding more than 20 board positions on national and state professional associations since 1984. Past positions for the Academy of Nutrition and Dietetics include the Board of Directors as Speaker-elect/Speaker/Past Speaker of the House of Delegates, Chair of the Council on Future Practice and Chair of the Dietetics in Health Care Communities DPG. She also served on the National Pressure Ulcer Advisory Panel for 10 years (6 years as a director). Honors include: Academy of Nutrition and Dietetics Medallion Award, Fellow of the Academy of Nutrition and Dietetics, and the Academy Award of Excellence in Business and Consultation.

Devoted to sharing information and teaching the next generation, Becky and her staff have been active clinical preceptors since 1982 hosting students from 6 colleges and universities in Ohio.

Contributing Editor:

Liz Friedrich, MPH, RD, CSG, LDN, FAND is a Registered Dietitian and president of Friedrich Nutrition Consulting in Salisbury, NC. The company provides a variety of nutrition consulting services with a focus on gerontological nutrition.

She has co-authored numerous articles in journals and magazines, including the Academy of Nutrition and Dietetics Position Paper titled Individualized Nutrition Approaches for Older Adults in Health Care Communities (2010) and Enteral Nutrition for Older Adults in Nursing Facilities (2011).

Liz was also the Associate Director of Nutrition411.com, a respected website for dietitians, and is an evidence analyst for the Academy of Nutrition and Dietetics' Evidence Analysis Library. In 2009 Liz became Board Certified as a Specialist in Gerontological Nutrition.

Liz has served as the Delegate for the Nutrition Entrepreneurs dietetic practice group to the Academy of Nutrition and Dietetics House of Delegates, and as a volunteer for the North Carolina Dietetic Association (NCDA) and the Nutrition Entrepreneurs Dietetic Practice Group (NE DPG) in many different board positions. She is the recipient of two North Carolina Dietetic Association awards, the Recognized Young Dietitian of the Year (1991) and the Member of the Year (2000).

We'd love to hear from you!
Please contact us at info@beckydorner.com or 1-800-342-0285.

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Foreword

This book is intended for use by skilled nursing facilities, nursing facilities, and other post-acute care facilities. Much of the language in the book is based on *Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities: A Rule by the Centers for Medicare & Medicaid Services (CMS)* released on 10/04/2016. When using the policies and procedures, also follow guidelines outlined by federal, state, and local authorities, including the Joint Commission and/or CMS.

The October 2016 rules issued by CMS add new language including language that:

- Designates dietary departments as "food and nutrition services" departments. This term will be used throughout this manual.
- Refers to nutrition care professionals as "qualified dietitians" (as defined below). For the purposes of this manual, the term Registered Dietitian Nutritionist (RDN) will be used most often with qualified dietitian used where appropriate.
- Allows a resident's attending physician to delegate the task of writing dietary orders, to a qualified dietitian or other clinically qualified nutrition professional who is acting within the scope of practice as defined by State law; and is under the supervision of a physician (1). It is incumbent on each qualified dietitian that is employed in or consults in a CMS-certified facility to check with state licensure or certification laws and work within facility policies and procedures before implementing order-writing as designated by a physician. While many of the policies and procedures in this manual mention orders written by a physician or designee, it is recognized that each facility may have adopted order-writing by the qualified dietitian, as delegated by the physician and in accordance with state law.
- Refers to "residents/patients" to describe the patient population unless the information is specific to nursing homes, and then the term "resident" will be used. For purposes of this manual, the terms "individual", "resident" and "patient" may be used interchangeably.

More information on these CMS Phase I guidelines can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-03-08-2017.pdf.

Note: At the time this publication was finalized, CMS had not yet implemented the Phase II Guidelines which include revised F Tag numbers and new survey process, effective November 28, 2017. As the new guidelines (with revised F-tag numbers) are implemented, the F-tags and some of the language in this manual may be different than the information on the following links.

- For more information on Revision to State Operations Manual (SOM) Appendix PP for Phase 2, F-Tag Revisions, and Related Issues visit https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf.
- CMS Phase III implementation is also planned for November 28, 2018. See the CMS website for more information: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf.

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Note: The following inservices can be downloaded from the link provided on your original order confirmation:

- Providing a Superior Dining Experience Inservice
- Producing Food That Entices Customers Inservice
- Respecting Residents' Right to Make Choices in Food and Dining Inservice

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Living in a skilled nursing or assisted living facility may not the preference for many people, but for some individuals it becomes a necessity. Unfortunately there are many misconceptions about the quality of care provided and what everyday life is like for people who live in health care facilities. Facilities that deliver person centered care give residents autonomy and choice in all aspects of daily living, and provide environments that are more homelike and less institutional. A major goal of these changes is to improve quality of life.

The Aging Population

The number of people aged 65 years or older numbered 44.7 million in 2013, the most recent year for which data is available. They represented 14.1% of the United States (U.S.) population, about 1 in every 7 Americans. (1). By 2040, there will be about 82.3 million older adults, more than twice the number in the year 2000. People 65+ represented 14.1% of the population in the year 2013 but are expected to grow to 21.7% of the population by 2040. The 85+ population is projected to more than double from 6 million in 2013 to 14.6 million in 2040 (1). These increases in the numbers of older adults will have a dramatic effect on our health care system in the future.

In 2013 only about 3.4% of people over age 65 lived in institutional facilities such as long term care (LTC) facilities. The percentage of people living in LTC facilities was higher for the older age groups; for example, 10% of people 85 and older in the U.S. lived in LTC facilities (1).

The Traditional Medical Model

The traditional skilled nursing environment of the past followed an institutional or medical model of care. The day revolved around the *tasks* to be accomplished, and the tasks were often performed to treat illness and meet state and federal regulations. In this model, the facility schedule dictated care. Residents were told when to get up, when to go to bed, when to eat, bathe, and when to take their medications. Independent choices were limited. Following this model, skilled nursing facilities (SNF) provided medical care, but did not always address basic human needs for relationships and connections with others. Care was perceived as impersonal and individual's rights and desires may not have been recognized to the fullest extent possible.

Changing the Culture of Long Term Care

Nationwide, long term care facilities have begun to change their image by changing the culture for residents, staff, and families. Each facility is in a different stage in the process of implementing this culture change, but changes can be seen in virtually every LTC facility in the U.S.

As an alternative to long term care, programs are in place to keep individuals in their homes as long as possible. Whether a person remains at home or enters a skilled nursing facility, living in a home-like atmosphere with privacy, choice, and control over their lives is the goal of care for older adults.

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Defining Culture Change

Culture can be defined in many ways, but one definition is “the ideas, customs, and social behavior of a particular people or society” (2). In long term care, the term “culture” is usually used to define the way of life in the facility.

Culture change" is the common name given to the national movement for the transformation of older adult services, based on person centered values and practices where the voices of elders and those working with them are considered and respected. Core person centered values are choice, dignity, respect, self-determination and purposeful living (3). Culture change supports the creation of both long and short-term living environments as well as community-based settings where both older adults and their caregivers are able to express choice and practice self-determination in meaningful ways at every level of daily life.

Culture change may require changes in organizational practices, physical environments, relationships at all levels and workforce models – leading to better outcomes for consumers and direct care workers without inflicting detrimental costs on providers.

The primary focus of culture change is to promote a better quality of life by implementing strategies that support person-centered care. Culture change can be very dramatic (for example, changes in building construction and layout of facilities). Changes in policies, schedules, and resident choices within the confines of an existing building are also an essential focus.

The Centers for Medicare and Medicaid Services (CMS) may have started the movement for culture change with the Nursing Home Reform Act, part of the Omnibus Budget Reconciliation Act of 1987 (OBRA). The objective of the Nursing Home Reform Act was for nursing facilities to care for each resident’s physical, mental and psychosocial well-being; and provide care that attains or maintains the highest practicable physical, mental and psychosocial well-being of each resident. The Act established a resident’s bill of rights, including the right to exercise self-determination (allowing one to make their own decisions), and to be treated with dignity (4). In recent years, CMS has been actively

involved in the culture change movement, working within their regulatory framework to improve quality of care and quality of life by emphasizing resident's rights and encouraging resident choice.

Person-centered care promotes what is typical for each person as the goal of daily care. To meet these goals, routines are adjusted to the individual's preferences as much as possible. Upon admission and periodically during a resident's stay at a facility, the facility staff, residents, and families discuss the individual's lifelong habits. Sleeping patterns, eating habits, and other daily routines are considered, and every task for each resident's care is structured to accommodate the individual resident's needs and preferences.

Basic Principles of Person Centered Care

Every facility approaches culture change differently, at its own pace, and with a different focus. However, the basic principles of person centered care usually include the following concepts (3,5-9):

1. **De-institutionalizing the setting as much as possible.**
   This includes asking the question, "Would we see this in a home setting?" There are no nurse's stations, medication carts, food carts, snack carts or loud speakers in a home, so the environment in a facility is altered as much as possible with this in mind. When possible, furnishings are less institutional and décor is home-like and comfortable.
2. **Maintaining a more normal living atmosphere.**
   Many facilities are constructing smaller living units or neighborhoods with a central living area and kitchen, and a small number of rooms that make up a "neighborhood". Regular meetings are held for those who live and work there to discuss topics relevant to everyday life in their neighborhood. Pets, plants, and music may be part of each neighborhood. Each neighborhood has a kitchen and dining room. Meals are served on each unit rather than in a large dining room, and residents have access to a small kitchen area.
3. **Maintaining a Committed, Stable Staff.**
   Ideally, each staff member works on the same unit consistently with the same residents and co-workers. This allows the whole team (including residents) to get to know one another and live and work together, and creates an atmosphere of family, caring, and community. All individuals are treated with dignity, respect and loving care. Often staff is cross-trained so they can serve as certified nursing assistant, dietary aide, and/or housekeeper for a neighborhood.
4. **Encouraging More Control over Decisions.**
   Privacy, dignity, and choices about daily life and the care residents receive is the key to person centered care. The individual is the focus, and is involved in care planning and setting daily routines. This usually begins with using "I" care plans: (for example, *"I prefer to eat breakfast at 9:00 AM…"),* and is carried out in every activity of daily living. Individuals are encouraged to continue lifelong habits,

rituals, and cultural routines. The facility staff listen to each individual's needs, empower them to make their own choices, and support their decisions.

5. **Using Participatory Leadership.**
   Leadership which promotes open, honest relationships, communications and trust among facility staff and residents is suggested for culture change to be successful. A participatory leader has a vision based on values; is a role model; enables others to make decisions and act on the vision; values the team; expects excellence; encourages creativity and original thinking; and gives staff authority that matches their level of responsibility for care.

6. **Implementing Systems to Support Relationships and Choice.**
   In the ideal setting, healthy relationships between both staff and residents are nurtured. People discuss things that are meaningful to them. This requires interpersonal skills and communication skills, caring and trust between team members. When culture change is the goal, teamwork that includes group processes and group decision-making often works best.

   Everyone who lives and works in a facility should be valued, supported, and involved in the process of creating an environment that includes manageable systems with a focus on the goal of nurturing the human spirit.