



DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Consortium – Division of Survey & Certification

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To: California Culture Change Coalition Person Directed Dining Pilot Project Core Committee
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From: CMS Region IX Survey and Certification Unit, and the Department of Public Health, Licensing and Certification.

CMS Contact Person: Retired Capt Eloise Beechinor, RD, MPH

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Subject: Centers for Medicare and Medicaid Service Region IX/ California Culture Change Coalition Person Directed Dining Pilot Project

As the California Culture Change Coalition (CCCC) moves into implementation of the Person Directed Dining Pilot Project, you have requested guidance regarding specific elements of person-directed care that you feel may put providers at risk for noncompliance with regulatory requirements. The main elements that you have asked the Centers for Medicare and Medicaid Services (CMS) Region IX and the Department of Public Health Licensing and Certification (DPH L&C) to comment on are:

- Honoring resident choice when therapeutic diet orders are in place and the residents' choice is not compliant with that diet order.
- Assessing intake and nutritional status of residents who participate in buffet style, family style, and/or free access to a resident refrigerator where portion sizes are not controlled, and the amount and types of food choices the residents makes may not be nutritionally balanced.
- Maintaining reasonable infection control precautions in a family style, and/or resident "snack center" situation where multiple residents may be touching bowls, utensils, and packages of food.

QUESTION 1:

*OBRA regulations support "self determination" and a resident's right to make choices about aspects of their lives that are important to them. Person-directed dining practices such as buffet and restaurant – style menus, and snack centers where residents have an array of food items from which to choose, expand the choices that residents have about **what** (types and kinds of food and fluids) **when**, (various times during a 24 hour day), **where**, (selected physical location such as choice of which dining room, activity room, outside such as on patio, bedroom, corridor, in front of the nurses station, **who** (alone or choice of which other residents, families, visitors, and/or staff), **how much** they want to be served (small or double portions, and/or seconds of some favorite food/s) and **how much** they want to eat (actual*

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intake). We anticipate that this may result in some instances where residents with clinically appropriate therapeutic diet orders will exercise their choice to eat types and/or amounts of food (more or less) that are not in keeping with those daily physician ordered diets. The CCCC recognizes that it is the responsibility of the facility to assess, monitor, plan, educate the residents about their risks, and work with the resident to provide care that is consistent with both their needs and their wishes.

- What other actions would the facility be expected to take in this kind of situation in order to have met their regulatory responsibilities to provide care and services to meet that individual's needs?

CMS RESPONSE to QUESTION 1:

CMS and DPH staff responsible for enforcing facility compliance with both the Federal regulations and California licensure laws recognize that it is the responsibility of the facility to **assess** each resident to identify their individual clinical and educational needs, preferences, and dehydration, under-nutrition, pressure ulcer and other dietary risk factors. On going resident assessment may be accomplished when the facility's direct care workers **observe, monitor and report** individual resident's actual food and fluid consumption. The facility is expected to act on their monitoring of on-going resident's independence/dependence to obtain adequate nutrition/hydration and clinical outcomes including but not limited to the presence of illness including wounds, medication effects, appetite/taste changes, depression, pain, difficulty in chewing and swallowing, infection and fever and nutrition and fluid intake through observation, weights, and (if indicated) lab tests. **Based on these assessments**, the facility should offer the residents opportunities to choose food and fluid alternatives that are compatible with their abilities to chew and swallow, dietary needs, and desires. The facility should also **educate** the residents (or their responsible decision-maker), in a manner that they can understand, about the risks and benefits of their healthy or unhealthy food choices and/or refusal of a therapeutic diet, and offer alternative foods and fluids while continuing to provide the therapeutic diet. We also recognize that in order to provide individualized care that meets each resident's needs, facilities will need to re-design their dining systems **with input from residents, staff and family if possible**. Facilities must also ensure that **staff is trained and available to provide individualized assistance**.

In general, for healthy individuals, the diets should follow available food guides. For example, in this population special consideration should be given to adequate sources of calories, protein and dietary fiber. All residents need to be individually assessed to determine if they could benefit from nutrient-dense foods, such as high fiber, additional calories, protein, iron, calcium, and/or other vitamin and mineral rich foods.

If any individual is eating and drinking foods and fluids that are not included within their individual designed therapeutic diet order, the facility, if possible, should **determine if the individual understands of any diet restrictions**. These individual residents should be allowed to dialog and respond to staff and others, with his or her specific reasons about why they are choosing to eat and drink foods that are not included within their individual designed therapeutic diet plan. **A discussion of each applicable resident's specific information should occur with the interdisciplinary team (all appropriate professionals involved) including the resident or resident's representative**. Health care workers would ideally communicate and share information with these residents, families, or significant others in ways that are useful to residents concerning his/her food and fluid consumption choices.

Staff participants may need to be flexible in allowing certain foods prohibited on any resident's dietary restrictions and focus on the role of nutrition in maintaining health in the nursing home's residents. While the facility is required to follow the doctor's orders for a resident's diet, staff participants may need to clarify information to the doctor regarding the resident rights and the role of nutrition in maintaining the resident's health and quality of life.

It is recommended that residents and families receive timely, complete, and accurate nutrition and hydration education information. Ideally residents' would use this information in decision making concerning his/her quality of life, resident rights and quality of care; that is choices and decision -making about what to eat, how much to eat, when to eat, where to eat and with whom to eat. Resident Councils and Family groups are opportunities for input, suggestions, planning, and education for implementation according to residents' choice and preferences regarding all aspects of eating, drinking, and dining. **On-going input should be solicited and considered from capable residents.**

Staff should use observation, active listening to residents with concurrent interviewing, clinical record documentation and information-sharing interventions. These methods must all be employed in an effort to solve any resident specific nutrition/hydration concerns and plan interventions that support the individual towards good clinical outcomes and satisfaction with his/her care including all aspects of the dining experience.

Remember to keep current individual resident assessments and documented evidence of planned interventions for any potential causal reasons (physical or psychosocial) for nutritional status decline, potential for dehydration or decline of lack of improvement in any resident's functional eating abilities. No facility should ever wait for resident weight loss before they act.

Key attributes of Resident –Centered Care:

Sufficient staff time and assistance must be provided to maintain eating abilities. (e.g., allowing residents enough time to eat independently or with limited assistance)

Nursing facilities need to establish a partnership among the health care practitioners including consistently assigned direct care staff, the long term and short stay residents and his/her families (when appropriate) to ensure that food and fluid decisions respect all these residents' wants, needs and preferences and that the capable residents, care givers and involved families are satisfied with their care, as well as their clinical outcomes. Coordination and integration of the nutrition and hydration services should involve and include clinical, ancillary, and support services staff. Capable residents should be encouraged to give on-going input about the program.

Key is respect for resident-centered values, preferences and expressed needs, including an awareness of quality-life issues, involvement in dining related decision-making, dining with dignity and attention to individual resident's needs and autonomy in food choices.

Health care workers who are consistently assigned to those individual residents need to listen, document any conversations, care conference discussions, and decisions of the resident and/or family regarding nutritional interventions in the individual resident's medical or clinical record and honor resident and family perspectives and choices. Resident and family knowledge, values, beliefs and cultural backgrounds should be known by these involved staff, and/or attempts to obtain this food and fluid history of food likes and dislikes, previous and current nutritional intake, each resident's eating habits and preferences, dietary restrictions, supplements and use of adaptive dining (eating) equipment.) This information should be used for consideration in incorporation into the planning and dining delivery for each resident's participating in the Directed Dining Pilot Project.

A Person - Directed Dining Pilot Project Quality Control System must be in place for monitoring and supervision of staff resulting in good outcomes for both staff and residents, and this system must be effective in identifying the root cause of any nutritional problems such as dental care or disease, dysphasia, ability to chew and swallow mechanically altered food, altered taste, hunger, uneaten meals do to lack of staff assistance, or mobility problems, etc.

It is recommended that each facility determine a system to demonstrate measurable outcomes towards excellence in resident-centered care as experts in implementing the Person Directed Dining Pilot Project.

Staff would be responsible for on going daily monitoring of each resident including any complications for any individual resident on a therapeutic diet and administering corrective actions as needed.

In summary, staff should take into account the resident's clinical condition such as history of being admitted underweight and malnourished, severe congestive heart failure, peripheral edema, history of dehydration, cachexia . Did the facility identify factors that put any individual resident at risk for malnutrition or dehydration? Did staff document any negative consequences and take action to prevent any potential or actual decline?

DPH L&C RESPONSE – ADDITIONAL REMARKS to QUESTION 1:

The provision of service would include the availability residents' food choices, variety, and accessibility as determined by the residents. Meal plans include variations in the number and sizes of meals and snacks as well as accommodation of resident preferences. A health professional's expertise is utilized to incorporate favorite foods; **however, there may be the rare instance when resident's choices can not be integrated.**

The question acknowledges the need for staff training and provision of individual assistance, however since culture changes includes changes for staff, it may be of benefit to identify that the training **should include staff's recognition when to act.** Perhaps in addition to individualized care, there are also benefits to create and establish systemic methods for staff to implement these nutrition approaches. **This would require the facility dietitian's coordination and involvement to ensure policies and procedures are created, are feasible to carry out and are implemented via trained and competent staff within the operational constraints of the facility.**

QUESTION 2:

*What is the CMS and DPH position on **liberalizing diets** to allow for more normalized menus for residents in skilled nursing facilities?*

CMS RESPONSE to QUESTION 2:

CMS Region IX supports the **Position Statement of the American Dietetic Association** that the quality of life and nutritional status of residents in long-term care facilities may be enhanced by liberalization of the diet prescriptions.

CMS advocated the use of qualified Registered Dietitians to assess and evaluate the need for therapeutic diets nutrition therapy according to each resident's individual medical condition, needs, desires, and rights.

Nutrition care must meet both maintenance of the highest practical level of physical, mental, and psychosocial health. It also must promote the highest practical "Quality of Life"; including the resident's satisfaction with the food, meal service and dining experience for each resident residing in these certified Nursing Facilities.

DPH L&C ADDITIONAL REMARKS to QUESTION 2:

Any changes to meals and diet order are part of the resident care planning meetings in which the resident and/or family members are included. Typically, the appropriate diet order is based on the intent of the medical care for this later stage of life and resident's choices. The benefit of therapeutic diets should be determined on an individual basis by the physician who is responsible for directing the resident's care and writing the diet order. Physicians are typically responsive to their patient's wishes and requests. **Care for the elderly population supports liberalized therapeutic diets as ordered by the resident's physician and have been successfully incorporated in skilled nursing facilities.** Health professionals can communicate to other care team members any occurrence that compromises a resident's medical condition or safety.

The facility should individually assess when a therapeutic intervention may be appropriate during a decline or a change of condition. **It would be appropriate to see the interdisciplinary team discussion during change of condition/declines as they relate to a less liberalized diet in order to address an acute phase. However, it would also be the facility responsibility to reassess and return to the liberalized diet once the acute phase of the change of condition was over.**

QUESTION 3.

*OBRA and state regulations require that food be stored, prepared and served in a manner that prevents contamination and the spread of food-borne illness. In supporting the practice of moving towards a "home-like" environment, facilities plan to offer residents a chance to serve themselves food in a "family – style" from communal bowls, or from a buffet or salad bar, and/or from a refrigerator where they will have free access to snacks. We recognize that it is the facility's responsibility to ensure that supervision is provided to protect that food from contamination, and/or to replace contaminated food before it is served. We also recognize that staff must ensure that food is **not allowed to cool or warm** to an unpalatable state during*

*the meal or snack service. Additionally we know it is the facility's responsibility to **ensure that the residents do not touch food that is available to other residents with their bare hands** and so proper serving utensils, training, and/or individual packaging must be in place in these situations.*

- *What other actions would the facility is expected to take in this kind of situation in order to have met their regulatory responsibilities to provide safe and palatable food?*

CMS RESPONSE to QUESTION 3:

Staff would be responsible for to ensure that food is served at residents' **preferable temperature** (hot foods are served hot and cold foods are served cold) as discerned by individual residents and customary practice.

Each facility should maintain a **policy and procedures** with a current list of what specific temperature the facility, will serve each food item on the menu and temperatures for each specific food items at when each resident receives their meal.

For example, you might consider such variables as hot foods that cool down rapidly at room temperature. These foods may need to be batched cooked, held and served when residents are ready to eat them in order to maintain palatable temperatures. Another example might be second portions of gravy could be held on the stove, not allowed to cool to unpalatable temperatures on the dining tables., until the residents are ready to serve themselves additional gravy. Soup could be held in a specially designed piece of equipment to hold the hot soup at the resident desired temperature.

DPH L&C ADDITIONAL REMARKS TO QUESTION 3:

The facility's responsibilities are succinctly presented in the question. Additionally, there should be some **form of time and temperature monitoring** to ensure both food safety and/or palatability. For buffets and snack centers, **food protection** is to be considered and for **resident safety** in the placement of hot items.

The development of systems and **training/competence assessment** for staff to implement this new system would be essential to the success of the culture change.

QUESTION 4:

*Are there certain resident- specific practices that the regulators would expect to be implemented such as providing hand sanitizer to residents before meals or refrigerator access, or limiting the access of individuals who **are hepatitis or MRSA positive**?*

CMS RESPONSE to QUESTION 4:

Facilities will need to re-design their dining system with input from residents, staff and possibly families. Person-directed care implies responsibility on the part of residents as well as protection of their rights. Residents should be encouraged to offer their strategies to address food safety and sanitation through a facilitated meeting to plan the resident access portion of

person-directed dining. Residents should review any new policies regarding person-directed dining to assure that they agree with the institution of the policies and to offer other suggestions or refinements. **For the vast majority of residents, simple precautionary steps will minimize the danger from acquiring or spreading pathogens.**

With a new dining system, all processes must be planned before initiation and will include consideration for practices that prevent the growth and spread of pathogens or germs. In keeping with general facility practice, Centers for Disease Control (CDC) **Standard Precautions** must serve as the guide for allowable practice. Monitoring of practice and behaviors is the keystone to success of this part of person directed dining. **Specific monitoring of plans, assignment of responsibility and developing appropriate tracking measures must be included in plans.** Results of monitoring should be shared through the **QAA Committee** and necessary changes made as needed. The person responsible for infection control for the facility should be consulted. Facility staffing levels must be adequate to not only provide for person directed dining, but also to **oversee and monitor the program for safety and effectiveness.**

The following comments are designed to address resident participation in person directed dining activities that include family style dining, self serving of meals or snacks and any food activities that involve groups of residents. **Any new Person-Directed practice must include facility consideration for control of the following: contact precautions and isolation of individuals infected with pathogens transmitted by contact, respiratory isolation of those who might transmit respiratory disease and control of the food environment to prevent environmental contamination.** Specific measures that must be addressed include the following (See Siegel, JD, et al, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, June 2007) (<http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf>):

1. Identification of individuals “at risk” for transmission of disease and specific plans for those individuals which might include use of mask or gloves.
2. High risk dining or cleaning activities that might need extra steps or protective measures.
3. Choice of dinnerware:
 - a. Regular china or dinnerware implies that strict control of personal use and proper cleaning will be conducted
 - b. Disposable dinnerware as appropriate to resident need and condition
4. Oversight and assignment of responsibility for this new activity must be clear and consistently applied.

Consideration of infectious agents with important infection control implications includes C.Difficile, Multidrug-Resistant Organisms (MDROs) and Hepatitis. Early identification of staff or residents with any of these conditions who are participating in person directed dining is most important in controlling the spread of such infections and implies that appropriate control measures will be taken based on CDC guidelines (www.cdc.gov).

1. **C.Difficile** control requires that any residents identified with this pathogen receive “Contact Precautions” and strenuous environmental control measures. Such residents are not appropriate for participation in person directed dining until cleared of the infection and with orders releasing them to participate in the dining program by their physician.

2. **MDRO** control is essential and primary to the well-being of all the residents and staff in a facility and any residents identified with MDROs must avoid the person directed dining program until cleared by their physician.
3. **Hepatitis A** can be transmitted via food and water and would preclude participation in person directed dining of a Hepatitis A positive resident or staff until no longer positive, while **Hepatitis B and Hepatitis C are NOT spread by food, water or casual contact. Thus, residents who may be Hepatitis B or Hepatitis C positive should be allowed to participate in person directed dining** and encouraged to follow the same guidelines as any other resident.
(<http://www.jan.wvu.edu/media/hep.html>)

DPH L&C ADDITIONAL REMARKS TO QUESTION 4:

The answer to your question is "no"; there are no resident - specific practices that would be appropriate for residents of a long-term care facility known to be carriers of any pathogen. **Standard ("universal") precautions are appropriate for any resident who can be maintained in a hygienic condition and are able to control or to have contained their secretions and excretions. Those who cannot may have special precautions applied,** but this should be on the basis of their condition, not knowledge or lack of knowledge of their status regarding carriage of any pathogen.