You Eat It First!

Integrating Personal Choice Into Dining Standards

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Objectives

- Understand the importance of food presentation and the dining experience. We use all of our senses when we eat. The aroma, appearance, color and texture of food all play a part in how much one eats, as does, the environment, those we eat with and those who serve or help us with our meals. F364 directly addresses palatability, attractiveness and temperature of foods served.
- Understand the regulations regarding the 2011 dining standards and diet consistency.
- Explore the idea of real food first versus vitamins.

What do you want for your last meal?

1. Beverage
2. Main course
3. 2 sides
4. Dessert

What's the Big Deal About Food?

*It's a multi-million dollar industry

Chick-Fil-A .....2.85 million

Krispy Kreme.....2.57 million

McDonald's.....2.5 million

* A projected 10.2 billion dollars will be spent in restaurants in 2016 in Missouri alone.

Why Presentation Matters

VS

What's Your Way?

- Plastic versus paper versus china versus Corelle.
  - It's been my experience that most people prefer to use regular dishes and cups. They tend to see paper and plastic ware as something to use at a picnic or bbq or when someone doesn't want to do dishes. If someone has tremors, they may need need a more substantial cup or utensils. Most people tend to do better with moderate weight service and dishes. If it's too heavy, they might not be able to use it. Preferences and needs should be assessed. F241 addresses dignity and appropriateness of dining facilities and service.
- How many forks does one person need?!
- The table cloth controversy
- Pass the gravy please…or not
- Fish day

20 Questions, the Foodie Way!

It's all about individuality!

- What time do you like to eat?
- What is your favorite salad dressing?
- Ketchup on eggs? Yay or nay?
- What do you like on your pizza?
- Are you a "salter?"
- Spice or no spice?
- What is your favorite summertime food?
- What would you consider your comfort food?
- How hot do you like your coffee?
- Coke or Pepsi?

No Two Taste Buds Are Alike

New(er) Dining Standards

Created in 2011 by a collaboration of the Pioneer Network and the Rothchild Foundation with contributions from

- American Association for Long Term Care Nursing
- Academy of Nutrition and Dietetics
- American Medical Directors Association
- Dietary Managers Association
- Gerontological Advanced Practice Nurses Association
- Hartford Institute for Geriatric Nursing
- National Association of Directors of Nursing Administration in Long-term Care
- National Gerontological Nursing Association
- American Association of Nursing Assessment Coordination

Agreement from 12 National Standard Setting Organizations…Unprecedented!

New Dining Practice Standards

- Diet Liberalization: Diabetic, Low-sodium, Cardiac
- Altered Consistency Diets
- Tube Feeding
- Real Food First
- Honoring Choice
- Shifting Traditional Professional Control to Support Self-Directed Living
- New Negative Outcome

Diet Liberalization

Problem

- Weight loss due to unappetizing therapeutic diets

Change

- Minimizing or taking out low-salt, low-fat, and sugar-restricted diets.

It is the position of the AND that the quality of life and nutritional status of older adults residing in health care communities can be enhanced by individualization to less-restrictive diets.

Medical nutrition therapy must BALANCE medical needs and individual desires and maintain quality of life.

The recent paradigm shift from restrictive institutions to vibrant communities requires dietetics professionals to be open-minded when assessing risks versus benefits of therapeutic diets, especially for frail older adults.

Diet Liberalization

- Dietitians, physicians, nursing staff and therapist must all be open minded about liberalization of diets. In acute situations, a restrictive diet may be medically necessary. However, when a dietary restrictions limits the amount of food, variety of food and frequency of meals, the consequences of the diet may outweigh the benefits. Each individual should be assessed by the RD to determine if the benefits of the diet outweigh the risk. Also, the RD should determine the resident's preference.

Tag F325 Nutrition, Deficiency

- Severity Level 4 - Immediate Jeopardy:

Substantial and ongoing decline in food intake resulting in significant unplanned

weight loss due to dietary restrictions or downgraded diet textures (e.g., mechanic

soft, pureed) provided by the facility against the resident's expressed preferences.

- Severity Level 3 - Actual Harm:

Unplanned weight change and declining food and/or fluid intake due to the facility's failure to assess the relative benefits and risks of restricting or downgrading diet and food consistency

F325 – Avoidable vs Unavoidable Weight Loss

- No specific diagnosis "qualifies" as being associated with unavoidable weight loss.
- Avoidable means the resident did not maintain acceptable parameters of nutritional status and the facility did NOT evaluate the clinical condition and nutritional risk factors; identify and implement interventions consisted with needs, goals and standards of practice; monitor and evaluate the impact of the interventions; and/or revise the interventions as need. This includes significant and insidious weight loss.
- If the facility did this things, then the weight loss would be unavoidable.

F325 – Assessment

- A nutritional assessment should include information about the resident's appearance; height; weight (including weight history); food and fluid intake; altered nutrient intake, absorption and utilization; chewing and swallowing abnormalities; functional ability; medication; laboratory and diagnostic data; wounds; goals and prognosis; and even environmental factors which may alter intake.
- The RD should make nutritional recommendations based upon the nutritional assessment be sure to clearly identify findings and plan.
- A plan of care should be developed based on the nutritional assessment.
- The RD should educated the resident and family as appropriate.
- REMEMBER, the resident has the right to make informed choices about accepting or declining care and treatment.

F325 – Weight Loss

- Weight loss may be beneficial for optimal health. The resident must be assessed by the RD for appropriateness and educated on weight loss interventions. If the resident is agreeable, goals should be clearly identified and progress should be monitored.

F325 – Weight loss as part of the disease process

- Decreased appetite and altered hydrations are common at the end of life. Often appetite and the ability to digest food is decreased which contributes to weight loss.
- Offer frequent small meals with preferences and tolerance in mind.
- Offer frequent drinks of tolerated fluids.

Medicalized Diets and Follow-Through

- Continuous monitoring and assessment. Nutritional assessments should be completed with a change in nutritional status, including, decreased or increased intake, weight loss or gain and changes in medical status.
- When potential interventions have the ability to both help and harm…the interventions should be reviewed by the dietitian in a holistic fashion and discussed with the resident and/or their family/POA prior to their implementation.

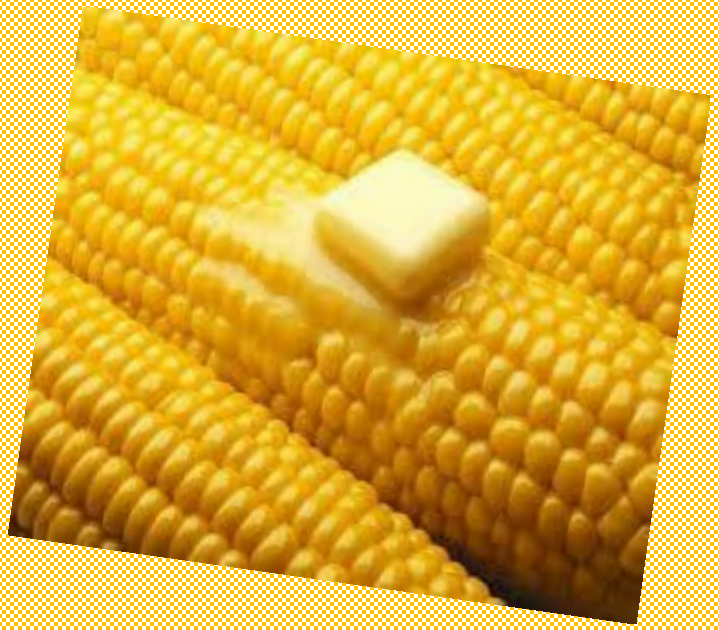
Diabetic Diets

- Diabetes can generally be managed with a consistent carbohydrate diets and medication adjustments.
- Sugar free or “diet” foods can contribute to elevated glucose levels.
- The resident should be assessed by the RD with goals and interventions identified, implemented, monitored and revised as needed.
- The RD should provide education as appropriate to the resident.

- Just released Feb. 2016 from American Diabetes Association…Liberal diet plans are preferable to therapeutic diets - more food choices benefit nutritional needs and glycemic control.

In the words of Marie Antoinette…
"Let them eat cake!"

Low-Sodium Diets



AND—recommends DASH (Dietary Approaches to Stop Hypertension)…reduces blood pressure, may reduce rates of heart failure…use DASH menu to help achieve these goals

NEWS FLASH: the typical 2 gram sodium diet recommended for people with hypertension has been shown to reduce systolic blood pressure on average by only 5mmHg and diastolic blood pressures by only 2.5mmHg. ***You could be more wrong by using the wrong size blood pressure cuff!*

Should only be used when the benefit to the individual is well-documented.

2 Gram Sodium Restricted Diets

- Specific foods may be required to be purchased and prepared.
- If one resident has an order for a sodium restricted diet, remember that others can have salt and prepare their meals accordingly.
- Foods low in sodium often lack the flavor to which residents are accustomed and my not be accepted which could contribute to decreased intake, nutrient deficits and weight loss.
- Often just encouraging avoidance of the salt shaker can significantly lower sodium intake.
- If a 2 gram sodium restricted diet is ordered, the RD should assess the resident for appropriateness and acceptance of the dietary restriction.
- The RD should educated the resident as appropriate.

Cardiac Diets

The effects of the traditional low cholesterol and low fat diets typically used to treat elevated cholesterol vary greatly and, at most, will decrease lipids by only 10-15%.

If aggressive lipid reduction is appropriate…it can be more effectively achieved through the use of medication that provides average reductions between 30-40% while still allowing the individual to enjoy personal food choices.

Should only be used when the benefit to the individual is well-documented.

Cardiac Diets

By significantly restricting sodium and fat in the diet, the taste of the food is altered. Also, foods allowed may be more difficult to consume. This type of restriction could promote weight loss and nutritional deficits. Each individual should be assessed by the RD to determine if the benefits of the diet outweigh the risk. Also, the RD should determine the resident's preferences related to the diet.

Altered Consistency Diets

#1 REASON PRESCRIBED??...Swallowing difficulties

NOTE: Dysphagia is not a diagnosis. It is a symptom commonly associated with conditions such as stroke, dementia, or Parkinson's disease.

AMDA—Swallowing abnormalities are common but do not necessarily require modified diet and fluid textures, especially if these restrictions adversely affect food and fluid intake.

AND—Older adults consuming modified texture diets report increased need for assistance with eating, dissatisfaction with foods, and decreased enjoyment of eating, resulting in reduced food intake and weight loss.

You Eat It First!

Altered Consistency Diets

CMS—take a holistic approach (NOT a one-size-fits all idea) Altered consistency should be implemented based on assessment of need and resident acceptance. The consistency needed should be clearly identified. Some foods may not need to be altered. Also, the food should taste like what it is only the texture should be altered. Staff assisting with dining should be aware of what all food items are and should inform the resident.

Not all residents with dysphagia aspirate or choke and all aspiration results in pneumonia. X-rays should not be done routinely. Consider if the resident exhibits symptoms of aspiration pneumonia.

Improved oral care can reduce the risk of developing aspiration pneumonia.

Altered Consistency Diets

- Choice and acceptance of altered consistency can contribute to malnutrition and dehydration.
- If a facility utilizes the Frazier free water protocol, make sure the protocol/policy is in place and is utilized.
- Encourage proper positioning and eating/drinking techniques as appropriate to reduce the risk of aspiration and promote intake.
- Prepare and serve food and beverages in accordance with assessed needs, physician's orders and the resident's preferences.
- Allow adequate time and staff assistance to promote intake.
- Residents who exhibit problems with chewing and/or swallowing may be self-conscious and do better in a more private setting with appropriate staff assistance.

Altered Consistency Diets…Tube Feeding

- Should not automatically be “the next step”
- May cause diarrhea, abdominal pain, and may *increase* the risk of aspiration

- Personal adage…when enough is enough…special circumstances and letting go
- Weigh benefits vs complications. Often residents and families are not realistic in their expectations related to tube feedings.

Recommendations

- Diet should be determined by the person, not the exclusively the diagnosis.
- Although a person may not be able to make decisions about certain aspects of their life, that does not mean they cannot make choices in dining. All decisions default to the person.
- Failure is imminent when others make decisions about your food.
- Assess the person's preferred context and environment for meals…routines, physical support, ability to use adapted eating utensils, timing of meals.
  - Are YOU a breakfast eater?
  - What are YOUR routines?

Real Food First!

- AMDA—provide foods of a consistency and texture that allow for comfortable chewing and swallowing. A resident who has difficulty swallowing may reject pureed or artificially thickened foods but may eat foods that are naturally of a pureed consistency like mashed potatoes, puddings, yogurt, and finely chopped may retain their flavor and be equally well-handled.
- CMS—with any nutrition program, improving intake via wholesome foods is generally preferable to adding nutritional supplements.

*Oral supplements often get wasted!

Real Food First!

- Consider additional small meals such as cottage cheese and fruit, ½ a sandwich, cereal and whole milk, ice cream, milk shakes and pudding made with whole milk in place of prepared oral supplements.

Waste By the Numbers

- If you have **159 beds**, then:

1.8 lbs/bed/day * 159 beds = 286 lbs/day

286 lbs/day * 7 days/week = 2,002 lbs/week = 1 ton of food waste per week

	Average Measurement		Material
Meals Served	0.6	lbs/meal	Food waste
Food Served	20	% of food served by weight	Food waste
Beds [1]	1.8	lbs/bed/day	Food waste

Source: RecyclingWorks, Massachusetts

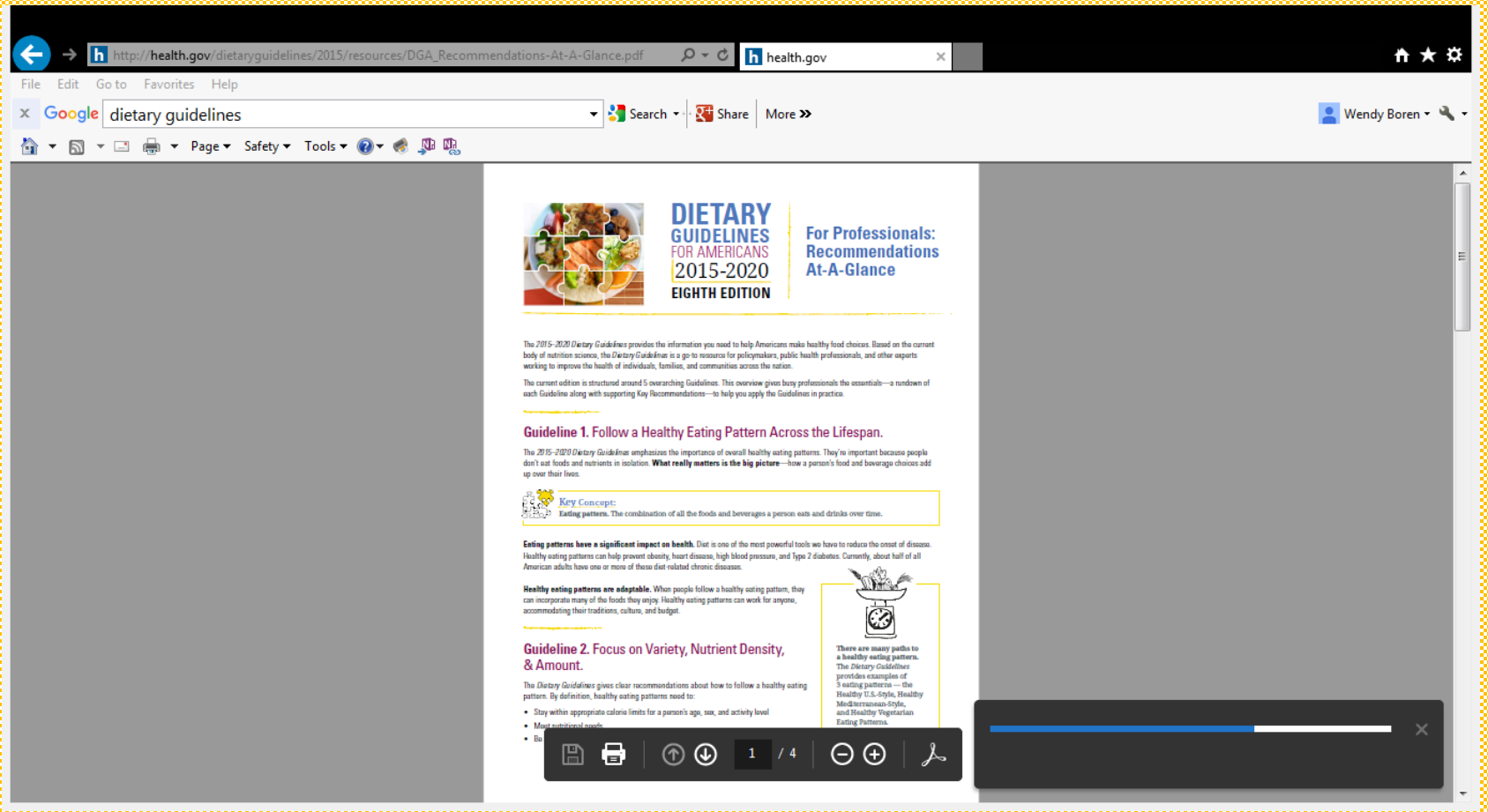
Real Food First

- Grow your own garden, with the residents help!
- Buy local
- Supplement calories with real ice cream or fruits or veggies packed full of vitamins and minerals

To increase nutrient intake, foods can be fortified with heavy cream, butter, gravies, sauces and dehydrated milk.

Dietary Guidelines 2015

Brought to you by Health.gov



Resources

- http://www.forbes.com/sites/caroltice/2014/08/14/7-fast-food-restaurantchains-that-rake-in-2m-per-store/#3fdbe970ce5a
- http://www.restaurant.org/Downloads/PDFs/State-Statistics/2016/MO_Restaurants2016
- http://recyclingworksma.com/food-waste-estimation-guide/#Jump05
- http://health.gov/dietaryguidelines/2015/resources/DGA_Recommendations-At-A-Glance.pdf
- https://pioneernetwork.net/Providers/DiningPracticeStandards/
- MU LTC manual