



Engaging Staff in Individualizing Care

Tip Sheet Flexible Dining Services

WHAT IT IS

Flexible dining services means that food is available for residents according to their customary routines. Meals are available over long periods of time with more variety, in tune with each resident's preferences. In the morning, food is available to accommodate early and late risers. Lunch and dinner times are served over a span of several hours to accommodate those who eat earlier and later. Preferred snacks are stocked where residents live and accessible at preferred times. Ideally, food is available and the kitchen is "open" on a 24 hour basis in order that all preferences are accommodated.

Flexible dining services supports eating as a social pleasure rather than a nutritional task. In homes that have adopted greater flexibility in practice, equipment, and routines, the outcomes for residents include greater enjoyment of food and dining, less unplanned weight loss, and less wasted food. The flexibility may include made to order food, plating of food in close proximity to residents so they can decide what they want at the time the food is available. Consistent staff know residents' particular preferences and needs. Real cooks prepare whole foods from scratch that residents enjoy eating. When clinical issues require special dietary considerations, these issues are addressed by taking into account residents' preferences in order to meet dietary requirements.

You probably already have followed meal time preferences for some residents or had occasional special cook-to-order breakfast days. Flexible dining makes these the norm instead of the exception.

WHY IT IS IMPORTANT

In many traditional nursing homes, meals are provided for residents on a fairly rigid time schedule. Meal times become hectic events, akin to a "rush hour." The time crunch can contribute to residents' agitation, falls, diminished appetite, and less enjoyment of the meal.

Many homes have night staff get up some residents to lessen the burden of getting everyone up and ready for breakfast for the day shift.

In some homes residents are up and dressed, slumped over sleeping in their wheelchairs as they wait for breakfast. Having a large meal set in front of someone before they are fully awake may result in the food not being eaten, and a social opportunity missed. For residents with dementia who are hungry at night and become distressed if their preferred snacks are not available, midnight snacking may be a better solution for their distress than antipsychotic medications. The key is “preferred” snacks; the goal with flexible dining is providing *any* snack a resident may desire.

Institutional meal delivery contributes to food waste and then high cost nutritional supplements to make up for what isn't eaten. Meals are a main event in most people's lives and they are a significant cost in daily nursing home operations. Institutional meal service is often one of the lowest rated areas in satisfaction, despite how much effort and cost goes into it. Homes that have spread out meal times, broadened choices, and shifted preparation and serving closer to residents have found that they are better able to meet residents' needs and preferences and have had more of their food actually eaten and enjoyed.

Being able to eat according to one's own routines is essential for well-being. Each of us has our own established pattern for what, where, when, and with whom we eat. We have comfort foods, favorite foods, and routines for our meals. Some of us even have a special seat at the table. When we don't eat according to our usual routines, we don't feel like ourselves. The social aspects of meals play a significant role in our enjoyment and therefore how well we eat. Poor nutrition has an enormous clinical and psychosocial impact. Yet, many people living in nursing homes don't eat well.

The New Dining Practice Standards developed by the Pioneer Network Food and Dining Clinical Standards Task Force references research findings that:

- ∞ *50%-70% of residents leave 25% or more of their food uneaten at most meals*
- ∞ *60%-80% of residents have a physician or dietitian order to receive dietary supplements*
- ∞ *25% of residents experienced weight loss*

The prevalence of protein energy under-nutrition for residents ranges from 23% to 85%, making malnutrition one of the most serious problems ... in long term care. Most residents with evidence of malnutrition were on restricted diets that might discourage nutrient intake.

Restricted diets and dietary supplements, given to prevent poor outcomes, carry their own risks. The New Dining Practice Standards support a shift from dietary *supplements* to dietary *preferences* by serving real food first and honoring residents' choices for when and what to eat. Given the importance of nutrition for health, and the impact on appetites when residents don't have options to eat what and when they are accustomed to eating, reinforces the importance of individualizing dining practices in providing a pathway to improving well-being for residents.

This interconnection between customary dining routines and quality outcomes is codified in the Nursing Home Reform Law's requirement that homes provide care and services to *"attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident."*

The federal nursing home regulations state under self-determination and participation, that: *"The resident has the right to—*

- (1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;*
- (2) Interact with members of the community both inside and outside the facility; and*
- (3) Make choices about aspects of his or her life in the facility that are significant to the resident."*

The CMS Quality of Life surveyor guidelines explain that: *Choices over schedules include: waking, eating, bathing, and going to bed at night, as well as health care schedules,* and state that the facility must:

- Actively seek information
- Be "pro-active" in assisting residents to fulfill their choices
- Make residents' choices known to caregivers

Surveyors ask residents whether they are able to eat according to their own routines and preferences. The CMS Partnership to Improve Dementia Care references these customary routines as surveyors explore the root cause of use of antipsychotics in response to a resident's distressed behaviors.

HOW TO DO IT

The four foundational organizational practices will aid you in making your dining services more flexible. Consistently assigned CNAs know their residents' dining preferences and work with staff from other departments through daily and QI huddles and the care plan meetings to make the arrangements needed to follow residents' customary routines.

- ∞ **Establish a QAPI Performance Improvement Project (PIP) Committee.** Begin by starting a committee that will see this process through. Include representatives from every department involved and affected by how food is provided to residents. For example, if rooms are usually cleaned during the time of the traditional meal, then housekeeping will need to figure out other times to clean rooms. Set the scope of what you want to accomplish in the long-range and determine short-term steps to get there. For instance, your long range goal may be to have food available whenever residents want it. Your first step will be to pilot test providing coffee and a continental breakfast in one resident living area. Pilot test with staff most willing and able to participate. Share the results with all staff along the way.

- ∞ **Use a building block approach.** Carefully look at what and how you are providing meals now and strategically build in flexibility. To open up breakfast, look at the easiest ways to lengthen the time that food is available first. A coffee urn filled and set on a timer for 5:00 AM provides coffee for early risers. A hotel style kettle for oatmeal provides early hot cereal and cold cereal dispensers in the dining room allow for cold cereal to be available at anytime. While these simple steps still require thinking through who will do what, they are building blocks for more difficult changes.

- ∞ **Re-evaluate therapeutic diets.** Many homes are now offering fewer specialized diets as residents' preferences are honored. If resident want foods not on their diet, rather than considering them as "non-compliant," explore plans *with* the person that work *for* the person. Following residents' preferences can help avoid problems such as the man who dislikes thickened liquids and will not drink them, and thus is at risk for multiple problems that stem from dehydration. Through care plan meetings and huddles, evaluate the risk and benefit and determine how to get them what they need by giving them what they want, with monitoring and support.

- ∞ **Offer real food first.** Offer real foods rather than supplements. Use whole grains and fresh fruits and vegetables, soups, and salads, and real meat. You'll need fewer supplements and digestive aids. Use dietary **preferences** instead of dietary **supplements**. For example, for a resident who loves eggs and needs extra protein to heal her wound, make eggs whenever she wants them rather than give her protein **supplements**.
- ∞ **Quality of Care + Quality of Life = Better Outcomes.** Using residents' customized routines to individualize dining maintains good health for residents and provides the guidance needed to address nutritional aspects of clinical issues. Knowing the person loves eggs gives the clinical team a way to increase protein through her preferred foods, which makes it an intervention more likely to succeed than offering foods she doesn't like and having to give protein supplements.
- ∞ **Build on your experience.** If you already have followed meal time preferences for some residents or had occasional special cook-to-order breakfast days, build on these experiences - if you can do it once or in exceptional cases, then how can you make it the norm? Use the exceptions and special days as pilot learning opportunities. Reflect: What did you need to do to get it done? How can it be done daily instead of only on special occasions?
- ∞ **Find ways to enhance the dining experience.** Equipment such as steam tables allow food to be served where it is eaten, and those who will be eating it to choose what looks good to them. Have more open access to dining rooms so residents can eat where and when they prefer. Serve soup as the appetizer. Offer happy hours with wine, cheese and chocolate. Have condiments on the table. Offer ethnic foods. Make all meals available for two and a half hours. Have a buffet three times a day. Have a full kitchen in the activities area. Have residents work as a committee to plan menus for the month.
- ∞ **Measure the impact.** Identify all data and information sources relevant to this change. Decide on the data you want to track to see how you are doing. Monitor clinical and psychosocial issues, such as weight, satisfaction with meals, and skin breakdown. Track wasted food, impact on other costs. Set small scale goals for small steps along the way.

RESOURCES

Pioneer Network www.PioneerNetwork.net

- ∞ Pioneer Network's website provides links to many affiliate organizations with resources to support homes in individualizing dining
- ∞ The New Dining Practice Standards developed by the Pioneer Network Food and Dining Clinical Standards Task Force (Toolkit will be available in Dec. 2013) at <http://pioneernetwork.net/Data/Documents/NewDiningPracticeStandards.pdf>
- ∞ Papers from the 2010 Creating Home II – National Symposium on Food and Dining Standards and Culture Change co-sponsored by the Pioneer Network and CMS, in collaboration with the American Health Care Association
- ∞ Promising Practices in Dining at <http://pioneernetwork.net/Providers/PromisingPractices/Dining/>
- ∞ The National Learning Collaborative's Webinar 5 provides information about the new dining standards and case examples of how these standards apply to complex clinical situations. Webinar 7 features a team of staff from a nursing home sharing information about how to operationalize customary routines in dining. They are available for a fee for five on-demand viewings of each webinar. All 12 webinars are also available for purchase as a set of discs, at a discounted rate. To purchase viewings of one or more of the webinars, or the entire package of 12 webinars, go to www.PioneerNetwork.net.
- ∞ This tip sheet is from the Pioneer Network Starter Toolkit: Engaging Staff in Individualizing Care. The entire toolkit, with additional tip sheets, starter exercise and resources, is available at www.pioneernetwork.net/Providers/StarterToolkit.

Advancing Excellence in America's Nursing Homes www.nhqualitycampaign.org

Data collection can help determine whether the changes being made are working, and continue to work. The Advancing Excellence in America's Nursing Homes campaign has the tools and excel sheets for collecting data on consistent assignment (are we REALLY

doing this?) and on Person Centered Care (are the wishes and preferences of the residents actually being delivered, and are the direct care workers attending and participating in the care plan meetings?), as well as other organizational and clinical goals. www.nhqualitycampaign.org

B&F Consulting www.BandFConsultingInc.com

Short videos excerpts on individualizing dining from CMS 4 part webcast From Institutional to Individualized Care available at www.BandFConsultingInc.com

All webinars in this series are available as archived recordings at http://eo2.commpartners.com/users/pioneerlive/all_series.php.

In addition, the full series is available as packaged DVD set in the [Pioneer Network store](#).