

Nutrition Care

Under New CMS Guidance

by | Linda Roberts, MS, RD, LDN

Can the CDM chart in a resident's medical record?

New CMS guidance and revised ADA Standards of Practice have many people asking that question. Some answers are offered here.

The Centers for Medicare & Medicaid Services (CMS) recently released F325, and the American Dietetic Association released revised Standards of Practice for the registered dietitian and dietetic technician registered, and people are asking me, “Can the certified dietary manager (CDM) chart in the resident’s medical record?” The simple answer is yes, with the next question being, “What can the CDM chart?” The answer to that is dependent on a number of factors, the first and foremost being state Practice Acts or state laws requiring licensure, certification, or registration for dietetics professionals.

State Licensure Laws

State licensure laws are developed to protect the public from harm. A simple example is the driver’s license. Possessing a driver’s license says the person knows the rules of the road, has experience driving, has passed a test, and will not harm others when behind the wheel of a car unless neg-



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ligent. The dietitian's license follows the same premise—education, experience, test, and evidence-based nutrition care of patients to prevent harm. The license also places responsibility for nutrition care upon the licensed dietitian. Keep in mind, if your state allows technical or support staff to assist the licensed dietitian in nutrition care and patient care is compromised, the licensed dietitian will be held accountable. The specifics of licensure laws vary from state to state; therefore it is imperative to understand the regulations, including scope of practice, for your state. It is within the regulations that you may find language, perhaps associated with the word *supervision*, to support the answer to, "What can the CDM chart in the medical record?" If your state's licensure law lacks language to support nutrition documentation by anyone other than the licensed dietitian, then the answer to the question becomes more complex.

The RAI, Nutrition, and Care Planning

Long-term care facilities are licensed by the state and must follow regulations and procedures to obtain and retain their license. Facilities providing healthcare services that are reimbursed by Medicare must have annual certification surveys to ensure the facility is following CMS rules and regulations. If these rules are not followed, defined consequences will befall the facility, with the most severe penalty being loss of certification.

CMS requires a comprehensive assessment called the Resident Assessment Instrument (RAI) be completed for each resident. The RAI consists of the Minimum Data Set (MDS) and, if triggered, the Resident Assessment Protocol (RAP). CMS regulations state the "RAI must be conducted or coordinated by a registered nurse (RN) who signs and certifies the completion of the assessment." It continues, "...while some aspects of the assessment process are dictated by regulation,

much flexibility remains for facilities to determine how to integrate the RAI into their day-to-day operations. For example, facilities should develop their own policies and procedures to accomplish the following...assign responsibility for completing sections of the MDS to staff who have clinical knowledge about the resident, such as staff nurses...dietitians."

This suggests that any staff member with clinical knowledge of the resident may complete the MDS; it does *not* mandate a licensed professional, i.e., the licensed dietitian. The completion of the care plan is assigned to "the interdisciplinary team (including a physician or other licensed healthcare practitioner...)." The other licensed healthcare practitioner may be the licensed dietitian, but it is typically the nurse.

CMS's regulation for nutrition care is F325. It states, "Based on the resident's comprehensive assessment [RAI], the facility must ensure that a resident—483.25(i)(1) maintains acceptable parameters of nutritional status, such

as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and 483.25(i)(2) receives a therapeutic diet when there is a nutritional problem." The only assessment piece cited in the rules of F325 is the "comprehensive assessment," also known as the RAI. CMS does not specifically mandate that the dietitian complete the RAI.

Within the overview of F325 it states, "Although the Resident Assessment Instrument (RAI) is the only assessment tool specifically required, a more in-depth nutritional assessment may be needed to identify the nature and causes of impaired nutrition and nutrition-related risks." It goes on to say, "Completion of the RAI does not remove the facility's responsibility to document a more detailed resident assessment, where applicable."

CMS does not mandate which professional must complete the more in-depth assessment, but clearly implies the significant role of the dietitian simply by using the term 'assessment'. ADA's Standards of Practice and DMA's Professional Practice Standards state the dietitian is responsible for the assessment of the resident. ADA defines the nutritional assessment as a "systematic process of obtaining, verifying, and interpreting data in order to make decisions about the nature and cause of nutrition-related problems." This does not mandate the dietitian collect and record data for the MDS, but it does imply the dietitian, when interpreting data, must verify its accuracy.

When the MDS is triggered, the next step in the RAI process is the RAP, Resident Assessment Protocol. CMS defines the RAP as a "problem-oriented framework for additional assessment based on problem identification items (triggered conditions). They form a critical link to decisions about

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care planning.” That means data triggered in the MDS must be interpreted. In other words, why was the MDS item triggered, and will providing an individualized plan of care enhance the resident’s quality of life?

Standards of Practice for the Registered Dietitian (RD)

RDs have a basic way of practicing nutrition care. These methods were taught in college, reinforced during the internship, used at work, and advanced through evidence-based practices. Patients can expect a certain level of nutrition care when being treated by an RD. Lawyers, when evaluating the merits of a malpractice suit, question whether or not the patient received the level of care given by a reasonably skilled practitioner within their community. Lawyers do not develop the standards for level of care for professionals. In the case of the RD, ADA develops standards from which the quality of practice and performance of RDs can be evaluated. ADA calls them the Standards of Practice (SOP) in nutrition care.

In 2008, the ADA Quality Management Committee revised the 2005 Standards of Practice in nutrition care and Standards of Professional Performance (SOPP) for the RD and the DTR. The 2008 SOP in nutrition care follows the Nutrition Care Process (NCP), which is a systematic process describing how dietetic practitioners provide care with patients. There are four parts to the NCP: Nutrition Assessment, Nutrition Diagnosis, Nutrition Intervention, and Nutrition Monitoring and Evaluation.

The Nutrition Assessment step is a method for obtaining, verifying, and interpreting data that is needed to identify the nutrition-related problem. The Nutrition Diagnosis is a critical step between nutrition assessment and nutrition interventions. It is the step in which the RD (or competent DTR) interprets the data in order to identify the problem and its root



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cause. In the Nutrition Intervention step, the RD (or competent DTR) initiates interventions that will improve the signs/symptoms of the problem and sets goals. The Monitoring and Evaluation step addresses the resident’s progress toward the goals and recommends changes in treatment as needed or discharge from nutritional care.

In addition to the NCP, the ADA SOP stresses the important team interaction of the RDs and DTRs. They reflect the minimum competency level of dietetic practice and professional performance for RDs and DTRs. The ADA SOP is *not* a government-imposed regulation. It is the standard of nutrition care against which an RD’s performance is likely to be measured in cases where issues arise. It is also the standards of professional practice that CMS refers to in F281.

Three parts of the revised ADA SOP in nutrition care are very important and clearly define the relationship of the RD and DTR.

1. The RD is responsible for the nutritional care of the resident.

2. The DTR, when performing nutrition care of the resident, works under the supervision of the RD.
3. The ADA SOP in nutrition care describes a *minimum* level of competence for RDs and DTRs who provide direct resident care.

ADA’s SOP in nutrition care does not include the CDMs, because Dietary Managers Association is responsible for Professional Practice Standards for its members.

Professional Practice Standards for the Certified Dietary Manager (CDM)

To become certified, the dietary manager must pass a nationally-recognized credentialing exam offered by the Certifying Board for Dietary Managers. This exam contains questions covering 10 competency areas, which fall under four major headings: Nutrition, Management of Food Service, Sanitation, and Human Resource Management. CDMs must successfully complete continuing education units (clock hours) in order to maintain their credentials and keep abreast of changes in long-term care.

The Professional Practice Standards provide the CDM with guidelines for documenting food history, food preferences, and food intake in the medical record. To view the Standards, please visit www.DMAonline.org/Resources/DMAResources/standard02.shtml

Standard 1: The CDM shall ensure that nutritional screening, food preference, and food acceptance are accurately obtained, monitored, and recorded in the medical record in accordance with state regulations and facility guidelines. The CDM shall ensure that food/fluid-related interventions are added to plans of care.

Standard 2: The CDM shall ensure that procedures for documenting nutritional assessment are established according to regulatory agency guide-

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lines or facility policy. Criteria 1.1: The CDM works with the dietitian to establish a nutritional assessment documentation procedure. Criteria 1.5: CDMs document nutritional screening data such as p/o intake, heights, weights, lab values, changes

in diagnosis, oral health status, or other parameters assessed by the dietitian. Criteria 1.6: CDMs will review intake records, do visual meal rounds, and document actual dietary intake. Criteria 1.7: Nutritional assessments and plan of care is verified and inter-

preted in the client's medical record by the dietitian.

These standards reinforce the vital relationship between the CDM and the dietitian. The CDM provides support in the systematic process of obtaining data so the dietitian can verify and interpret the data to make decisions about the nature and cause of nutrition-related problems and prescribe appropriate nutrition interventions.

Task Force Formed to Clarify Role of Certified Dietary Managers

Dietary Managers Association® (DMA®) and the Certifying Board for Dietary Managers® (CBDM®) have formed a task force to clarify roles and responsibilities of Certified Dietary Manager, Certified Food Protection Professionals (CDM®, CFPP®s), announced Katherine Church, RD, Executive Director of the CBDM. The task force composed of Registered Dietitians (RDs) who work as nutrition consultants within the long-term care industry, along with representatives of DMA and the CBDM, will be gathering information, evaluating industry models, and releasing a role delineation tool, said Church.

"Two factors in the industry triggered formation of a task force," said Church, chiefly:

- A new, standardized nutrition care process outlined by the American Dietetic Association is being implemented in the healthcare industry today. "CDM, CFPPs have long played a role on the healthcare team, especially in long-term care. The task force needs to determine how the training and certification of CDM, CFPPs integrates with steps in the nutrition care process, the Resident Assessment Instrument, and the day-to-day needs of residents," Church said. "We will be examining aspects as simple as terminology, to promote clear definitions and common language among professionals," she added.
- Revised guidance for surveyors issued by the Centers for Medicare & Medicaid Services (CMS) addresses nutrition for long-term care residents (F325—Nutrition) and took effect September 1, 2008. "We are committed to ensuring that everyone involved in nutritional care can have a clear picture of CDM, CFPP role delineation in a systematic approach to nutritional care," said Church. "CDM, CFPPs typically perform nutrition care tasks coordinated by RDs, and we are very pleased to have multi-disciplinary collaboration on this task force," she said.

About the Credential

The CDM, CFPP credential is held by more than 90 percent of DMA's nearly 15,000 members. Certified Dietary Managers are trained and qualified to manage menus, food purchasing, and food preparation; and to apply nutrition principles, document nutrition information, ensure food safety, and manage work teams, as outlined in detail in the CDM, CFPP Scope of Practice. They have passed an exam administered by the professional testing firm, ACT, Inc., and complete ongoing continuing education to maintain certification. The certification program is accredited by the National Commission for Certifying Agencies (NCCA). For more information, visit www.DMA-online.org or www.CDMcareer.info

CMS - F281

What's the big deal about ADA's SOP or DMA's Professional Practice Standards if they are not government regulations? The answer is F281 483.20(k)(3) "the services provided or arranged by the facility must (i) meet professional standards of quality." The intent goes on to say "professional standards of quality means services that are provided according to accepted standards of clinical practice. Standards regarding quality care practices may be published by professional organization, licensing boards..." It's brilliant, actually. CMS does not have the expertise to set professional standards for each healthcare provider, so it mandates the healthcare provider follow the standards mandated by their professional organization or licensing board which we know is ADA's SOP, DMA's Professional Practice Standards, and state Practice Acts.

Bottom Line

A state's Practice Act trumps the minimum standards set by CMS and a professional organization's standards of practice. In the absence of an all-inclusive, state Practice Act's scope of practice, the DTR or CDM may assist in the nutrition care of the resident by collecting data that is verified and interpreted by the dietitian (or competent DTR). The dietitian's in-depth assessment may be used as the RAP when the assessment identifies the MDS triggers, interprets the MDS data as it relates to the resident's

nutritional condition, and makes the decision to proceed or not to the care plan. The recommended in-depth assessment model is the Nutrition Care Process.

The dietitian must work with each facility to develop policies delineating the responsibilities of the RD, DTR, and CDM based on their competencies. Policies must outline the systematic processes used by the facility to screen and nutritionally care for their residents. Protocols, developed by the dietitian and approved by the facility, may be put into place to care for the resident between consultant dietitian visits.

Together the RD, DTR, and CDM can systematically provide for the nutrition care of the resident and impact quality of life. ■

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