



Introduction

“Person-directed care” is a philosophy that encourages both older adults and their caregivers to express choice and practice self-determination in meaningful ways at every level of daily life. Values that are essential to this philosophy include choice, dignity, respect, self-determination, and purposeful living. These values are also at the core of desirable medical care and are embraced by many medical providers. Yet practices that conflict with these principles are common in the long-term care setting. Examples include waking residents at times that are determined by staff convenience, modifying residents’ diets without discussion, and inflexible mealtimes and medication pass times. In addition, care plans may be created without truly understanding a resident, their history or previous occupation, their recreational and personal preferences, wishes regarding life-sustaining treatment, and other likes and dislikes.¹

The discipline of Geriatrics emphasizes medical care in the proper context, where there may not be a right or

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The Role of the Certified Dietary Manager in Person-Directed Dining

Dietary Managers Association Position Paper



“An elder’s right to have a liberalized diet, or even the elimination of caloric and other dietary restrictions, has slowly been embraced to enhance quality of life. But many dietitians and CDMs, along with the interdisciplinary team, resist the elder’s right to have an informed refusal of an ordered diet...”

wrong decision, but rather a weighing of the impact on quality of life, potential for decline, and personal preferences. Advocacy groups such as the Pioneer Network promote person-directed care in the long-term care setting.² In addition, alternative approaches to nursing home care have become more prevalent over the past decade. Examples include the Eden Alternative, the Green House Project, the Planetree Model, and the Wellspring Model.

The American Dietetic Association’s Position Papers on Liberalizing the Diet³ and Individualized Nutrition Approaches for Older Adults⁴ have supported these concepts. Many Certified Dietary Managers (CDMs) have embraced the application of these philosophies and assisted their facilities in providing residents with more choice in their care.

Initially, the federal OBRA ’87 regulations and accompanying survey process were intended to ensure that residents were provided dignity, rights, and self determination in their care. Over the years, these dining rights (mainly identified as the right to have food preferences honored) were supported if they did not interfere with what was perceived as regulatory compliance with all the other nutrition and dietary requirements. Facilities became more and more institutionalized as they focused on ensuring “good dietary/nutrition care.” Surveyors were evaluating facilities based on these nutrition and dietary regulatory requirements.

Physicians ordered the therapeutic diet restrictions that had been assessed or recommended for a resident’s diagnosis or medical needs. Kitchen tray lines operated like clockwork to provide resident trays with exact portions of a planned menu and modified diets, and only the acceptable condiments. Trays were sent to dining rooms to be placed before residents, usually without place settings being removed from the tray. Staff schedules revolved

around getting residents ready for mealtimes (bacon and eggs or breakfast menu at 7 a.m., lunch at noon, and dinner at 5 p.m.). Mealtimes were planned for staff convenience (all trays needed to be back before the dishwasher clocked out) and to meet the stated regulatory requirement (F-Tag 368: No greater than 14 hours could elapse between the evening meal and the breakfast meal.). An evening snack was required to be offered (hs snack usually offered at 8 p.m., then lights out). Families often brought in food for a specific family member, but it could not be shared. Residents were never invited to staff potlucks—though residents could smell the aromas of the event—as these were potentially unsafe food preparations and transport that did not have the trained dietary staff supervision.

Greater emphasis on resident rights and choice was emphasized in the revision of the guidance to surveyors of the Quality of Life tags in June 2009. The Centers for Medicare & Medicaid Services (CMS) revised the State Operations Manual, Appendix PP—Guidance to Surveyors for Long Term Care Facilities as it relates to several federal tags concerning quality of life and environment. Noteworthy changes to the interpretive guideline for F-Tag 242 (Self-Determination and Participation) included the statement:

“Residents have the right to have a choice over their schedules, consistent with their interests, assessments, and plans of care. Choice over “schedules” includes (but is not limited to) choices over the schedules that are important to the resident, such as daily waking, eating, bathing, and the time for going to bed at night. Residents have the right to choose health care schedules consistent with their interests and preferences, and the facility should gather this information in order to be proactive in assisting residents to fulfill their choices.”⁵

F-Tag 325 (Maintaining Nutritional Status) emphasizes the requirement to consider the resident’s preferences in de-

termining if a therapeutic diet or restriction is to be ordered. The revision of September 2008 states:

The intent of this requirement is that the resident maintains, to the extent possible, acceptable parameters of nutritional status and that the facility: Provides a therapeutic diet that takes into account the resident's clinical condition, and preferences, when there is a nutritional indication.⁵

In May 2009, a CMS memo on Food Procurement and guidance was provided to facilities. It clarified the following:

- That residents have the right to choose to accept food from visitors, family, friends, or other guests according to their rights to make choices of self determination
- That these non-facility foods are not subject to regulatory requirements of F-Tag 371 (Sanitation & Food Safety)
- The responsibilities of the facility in providing food safety information to family/staff and the safe handling of visitor foods once it is in the facility.⁶

Concerns

Identifying the proper balance between medical complexity—which may require medications, modifications, and restrictions—and allowing for personal choice, is the essence of good geriatric medicine. Individualized care should seek to understand the entire person, to focus attention on the medical, functional, and psychosocial aspects of the resident. The interdisciplinary team (IDT) should consider the potential effects of proposed interventions on the resident, rather than simply the treatment or protocol's effect on a disease. For example, some residents who remain in bed until they wake on their own may develop pressure ulcers or lose weight, although most will not. Most residents will appreciate having these choices, and the team can weigh the benefits against the risks and work with the resident and/or family/POA to establish an effective individualized plan of care.⁷

An elder's right to have a liberalized diet, or even the elimination of caloric and other dietary restrictions, has slowly been embraced to enhance quality of life. But many dietitians and CDMs, along with the interdisciplinary team, resist the elder's right to have an informed refusal of an ordered diet (texture modified or tube feeding) that might put them at aspiration and choking risk. Often this is based on the long held, preconceived notion that federal regulatory requirements (and possibility of a deficiency finding) are for safety first, and quality of life decisions take a second seat after that. It is also based upon years of *not* informing the resident that these choices were his/her rights, and *not* including the resident's voice or preference in the dietary planning and decision making. Yet, the F-Tag 151 federal requirement states its intent regarding the facility's responsibilities toward rights:

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Task Statements for the Certified Dietary Manager

1. Empowers and honors the resident and quality of life first and foremost by getting to know the resident, listening to the resident's preferences/goals in dining, and informing the resident of dining rights.
2. Builds an ongoing relationship with the resident that includes quality of life markers such as satisfaction with food, mealtime service, level of control, and independence.
3. Collaborates with the dietitian, other interdisciplinary team (IDT) members, and the family/POA or surrogate decision makers to create a person-directed environment and maximize resident choice in dining, quality of life, and quality of care.
4. Recognizes that all dining decisions default to the resident, works toward removing traditional or institutional decision making, and implements creative, effective solutions based on person-directed decision making.
5. Encourages active resident participation in changing the language of nutrition care plans away from the problem-goals-approaches format, to promoting the incorporation of resident preferences and goals into development of an individualized plan of care.
6. Collaborates with the dietitian and other IDT members to develop, implement, and review policies and procedures that ensure residents are offered dining choices that promote dignity and self determination (e.g., choices regarding waking times and breakfast dining, evening snack times, availability of preferred food between meals, liberalizing diets, discussions of risk/benefits in making informed choices/refusal of therapeutic diets).
7. Participates in orienting, training, and monitoring staff in promoting individualized dining care.
8. Participates in maintaining and continually improving the quality of care (e.g., helps develop quality assessment and assurance projects that monitor the success of person-directed dining approaches).
9. Continues to seek information in order to implement the best practices and recognized standards of practice for elder nutrition care and person-directed dining.
10. Ensures regulatory compliance for a resident's dignity, rights, and self determination in dining areas, as well as supports the maintenance of nutrition markers, food safety, and other dietary requirements.

“Exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care.” This includes the right of refusal of an ordered medical therapy or diet. The surveyor is to “Pay close attention to resident or staff remarks and staff behavior that may represent deliberate actions to promote or to limit a resident’s autonomy or choice.”

Each facility must answer the questions: How is the resident informed about dietary/dining rights? Does the resident have a voice or is it limited? Is there educating and informing the resident about alternatives and consequences of choices? Is there a mutually agreed-upon plan recognizing the resident’s choice? Is there adequate resident support and monitoring once that informed refusal is made? Remember the challenges when there were federal mandates for removing physical and chemical restraints for a resident’s quality of life? There will always be safety issues and concerns. We are facing some of the same challenges in supporting a resident’s informed refusal and right of choice.⁷

In 2010, CMS/Pioneer Network held their second co-sponsored national symposium, Creating Home II National Symposium on Culture Change and the Food and Dining Requirements.⁸ Please see symposium topics and their pdf files in the Bibliography reference at the end of this paper.

Two of the numerous recommendations for future consideration were:

- National stakeholder workgroup develop guidelines for clinical best practice for individualization in long-term care living to provide regulatory overview and interpretive protocol and investigative guidance, and prepare related education materials to facilitate implementation.
- Each profession serving elders in long-term care develop and disseminate standards of practice for their professional accountability that addresses proper training, competency assessment, and their role as an active advocate for resident rights and resident quality of life from a wellness perspective, in addition to quality of care from a medical perspective.

These recommendations were acted upon, and in 2011 the national stakeholder groups (including Dietary Managers Association) participated in developing and agreeing on new individualized standards of practice moving away from traditional diagnosis-focused treatment to individualized care supportive of self-directed living. (Anticipated out in fall 2011.)

The Certified Dietary Manager can have an effective role in ensuring resident rights, choice, and self determination. The CDM is often the first responder in interviewing residents, gathering appropriate information, informing resi-

dents of their rights, and in ongoing reevaluation of their nutrition/dining status. The CDM can be an effective collaborator with the dietitian and IDT to implement person-directed dining. DIETARY MANAGER magazine has provided many articles on resident-directed dining, including an article titled, “Your Role in Ensuring Culture Change in Dining and Regulatory Compliance,” (June 2010) that defined the role of the CDM and a review of the CMS/Pioneer Network Symposium topics.⁹ As best practices and new standards of practice for resident-directed dining are identified, the CDM is in a pivotal role to help implement them.

Competency

Dietary Managers Association supports the philosophy of person-directed dining and believes that it can promote improved quality of life for long-term care residents. The Certified Dietary Manager has an essential role in promoting this individualized nutrition/dining care, as well as helping to ensure quality of life and quality of care.

A Certified Dietary Manager, Certified Food Protection Professional (CDM, CFPP) has passed a nationally-recognized credentialing exam offered by the Certifying Board for Dietary Managers. Continuing education is required to maintain these credentials. The exam is written by content experts, and administered by The American College Testing Program (ACT). The CDM, CFPP credentials indicate that these individuals have the training and experience to competently perform the responsibilities of a dietary manager. CDM, CFPPs work together with registered dietitians to provide quality nutritional care for clients, and perform the following tasks on a regular basis: (CDM, CFPP Scope of Practice)

- Conduct routine client nutritional screening which includes food/fluid intake information
- Calculate nutrient intake
- Identify nutrition concerns and make appropriate referrals
- Implement diet plans and physicians’ diet orders using appropriate modifications
- Utilize standard nutrition care procedures
- Document nutritional screening data in the medical record
- Review intake records, do visual meal rounds, and document food intake
- Participate in client care conferences
- Provide clients with basic nutrition education¹⁰

The Certifying Board for Dietary Managers believes it is in the best interests of the profession and the public it serves that a Code of Ethics provides guidance to Certified Dietary Managers in their professional practice and conduct. Following is an excerpt from the CDM Code of Ethics:

- The Certified Dietary Manager practices dietary management based on professional principles
- The Certified Dietary Manager assumes responsibility and accountability for personal and professional competence in practice
- The Certified Dietary Manager exercises professional judgment within the limits of his/her qualifications and seeks counsel or makes referrals as appropriate
- The Certified Dietary Manager provides sufficient information to enable clients to make their own informed decisions.¹¹

The CDM who works in long-term care is expected to seek continuing education and information in order to implement the best practices and recognized standards of practice for elder nutrition care and person-directed dining.

Summary

Person-directed dining promotes resident choice and self-determination in ways that are meaningful to the resident and, hence, their quality of life. The Certified Dietary Manager, in collaboration with the dietitian and the interdisciplinary team, has an essential role both in facilitating this process, as well as in monitoring it for desired outcomes. **DM**

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11. Certified Dietary Manager Code of Ethics, <http://www.DMAonline.org/Docs/codeEthics.pdf>

*CMS/Pioneer Network Symposium Topics:

The Food and Dining Side of the Culture Change Movement: Identifying Barriers and Potential Solutions to Furthering Innovation in Nursing Homes by Carmen Bowman, MHS, <http://www.pioneernetwork.net/Data/Documents/dining%20symposium%20background%20paper%201-28-10.pdf>

Food for Thought: The Missing Link Between Dining and Positive Outcomes by Dr. Judah Ronch, PhD, Interim Dean of the Erickson School, <http://www.pioneernetwork.net/Data/Documents/CreatingHomeOnline/Paper-Ronch.pdf>

Survey Interpretation of the Regulations by Linda Handy, MS, RD, Consultant, Retired Specialty/Trainer Surveyor CDPH, <http://www.pioneernetwork.net/Data/Documents/CreatingHomeOnline/Paper-Handy.pdf>

The Role of the Physician Order by Matthew Wayne, MD, CMD, Medical Director University Hospital Health System Senior Services, Geriatric Services Southwest General Hospital, University Hospital Foley ElderHealth Center, Legacy Health Care and Provider Services, Karyn Leible, MD, CMD, Chief Clinical Officer for Pinon Management and Vice President for the American Medical Directors Association, <http://www.pioneernetwork.net/Data/Documents/CreatingHomeOnline/Paper-WayneandLeible.pdf>

The Deep-Seated Issue of Choice by Linda Bump, MPH, RD, LNHA, Culture Change Consultant and Trainer, <http://www.pioneernetwork.net/Data/Documents/CreatingHomeOnline/Paper-Bump.pdf>

Outcomes of Choice in Dining—Home-Style Dining Interventions in Nursing Homes: Implications for Practice by Robin Remsburg, PhD, GCNS, FAAN, Director, School of Nursing, and Associate Dean, College of Health and Human Services, George Mason University, <http://www.pioneernetwork.net/Data/Documents/CreatingHomeOnline/Paper-Remsburg.pdf>

Food, Pharmacy and Culture Change: A Recipe for Success by Denise Hyde, Pharm.D., RP, Community Builder Eden Alternative Inc., <http://www.pioneernetwork.net/Data/Documents/CreatingHomeOnline/Paper-HydeandOgden.pdf>

Enhancing the Quality of Nursing Home Dining Assistance: New Regulations and Practice Implications by Rosanna Bertrand, PhD, Abt Associates Inc., Sandra Simmons, PhD, Vanderbilt University, Center for Quality Aging, <http://www.pioneernetwork.net/Data/Documents/CreatingHomeOnline/Paper-SimmonsandBertrand.pdf>

The Food Code and CDC Infection Control Guidelines (only webinars, no papers), Glenda Lewis, MSPH, FDA Office of Food Safety, Nimalie Stone, MD, MS, Centers for Disease Control