CURRENT “BEST PRACTICE”

Standards for Nutrition in Long Term Care

Presenter:
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Objectives- Attendees can:

• Identify current Best Practice standards with Nutrition and Aging.
• Discuss current Best Practice standards with Nutrition related to Wounds, and Hydration
• Know available Best Practice Resources to support implementation at the Facility Level
WHY FOCUS ON NUTRITION?

Malnutrition is a major contributor to:

- increased morbidity and mortality,
- decreased function and quality of life,
- increased frequency and length of hospital stay, and
- higher health care costs.

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I. Know what "Best Practice" Is for LTC
II. Facility Team Management
III. Facility Systems and Processes

- Federal
- State
- Professional Organizations
- Identify the Team
- Team Responsibilities
- Staff/Residents/Families
- Programs
- Policies/Procedures
- Training/Education
- QI/QAPI Customers
- Vendors/Contracts
RESOURCES:
• Federal
• State
• Professional Organizations

I. Know what Nutrition "Best Practice" is for LTC

Examples of Resources for Best Practice

- State and Federal Gov Agencies (CMS, SDH, Health Dept, AoA, etc)
- Professional Organizations (AND, AMDA, NPUAP, CDC, etc)
- CONSUMER & Consumer Organizations (AARP, NCOA, etc).

Others: QI0s, Pioneer Network, USDA, CDC, FDA, AMDA, ASPEN, etc.
REMEMBER THAT “WHATEVER NUTRITION ASSESSMENT AND CARE PLANNING RESOURCES ARE USED, THEY ARE EXPECTED TO BE:

- CURRENT,
- EVIDENCE-BASED OR EXPERT-ENDORSED RESEARCH AND CLINICAL PRACTICE GUIDELINES/RESOURCES”

II. Facility Team Management
Identify a Nutrition “Oversight” Team

- Nursing
- Registered Dietitian
- Dietary Manager/ Diet Technician Registered
- Speech Language Pathologist
- Quality Improvement
- Medical Director
- CNAs
- Others (Pharmacist, Occupational Therapist, etc.)
Facility Team

Identify Team Responsibilities

- Nursing/ Director of Nursing, Unit Mgrs, CNAs, others
- Registered Dietitian (Licensure/Certification, Skills and Competencies, Professional Involvement)
- Dietary Manager/ Diet Technician Registered
- Speech Language Pathologist
- Quality Improvement
- Medical Director
- Others (Pharmacist, Occupational Therapist, etc.)

Facility Team

Communication with Staff, Residents and Families

- In-services
- Newsletters/memos
- Department Head Meetings
- Change in Shift Meetings
- Care Plan Meetings
- Others (Website, etc)
III. Systems And Processes

- Key Facility Nutrition Programs
- Nutrition Manuals/Care Manuals
- Menus and Vendor Programs
- Customer Satisfaction
- Quality Improvement

III. Systems And Processes

- Key Facility Nutrition Programs
  - Food service and Dining programs
  - High Risk Nutrition
  - Weight monitoring program
  - Hydration program
  - Skin and wound care program
  - Real Food/Nutritional supplement program
  - Quality Improvement program
III. Systems And Processes

Manuals:

- **Policy/Procedure Manuals:**
  - Current, Best Practice, Reflect What your Facility Does, Staff is educated/trained.

- **Diet Manual:**
  - Current and Best Practice

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III. Systems And Processes

Manuals: State Operations Manual (SOM)

- Requirements in 42 CFR Part 483, Subpart B,
- Know The Survey Process, Survey Forms, Appendix P - Survey Protocol for Long Term Care Facilities - Part I and Appendix PP - Guidance to Surveyors for LTC Facilities
- Know the Deficiency Criteria and Determination and the Plans of Correction
III. Systems And Processes

Manuals:
• RAI Manual
• Additional References
• Client Education Material

Customer Satisfaction - Resident Council, Newsletters, Surveys
- Be present during all meals and get input.
- Provide follow-up and responsiveness.


Quality Improvement: - Nutrition Programs, Weights, Heights, QI/QAPI, Dining, etc.
Nutrition

NUTRITION F325 SOM

§483.25(i) Nutrition
Based on a resident’s comprehensive assessment, 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.

Source: State Operations Manual
Appendix PP - Guidance to Surveyors for Long Term Care Facilities
Accessed Online 2/8/2014
NUTRITION F325 SOM

INTENT: §483.25(i) Nutritional Status

The intent of this requirement is that the resident maintains, to the extent possible, acceptable parameters of nutritional status and that the facility:

- Provides nutritional care and services to each resident, consistent with the resident’s comprehensive assessment;
- Recognizes, evaluates, and addresses the needs of every resident, including but not limited to, the resident at risk or already experiencing impaired nutrition; and
- Provides a therapeutic diet that takes into account the resident’s clinical condition, and preferences, when there is a nutritional indication.

Source: State Operations Manual
Appendix PP - Guidance to Surveyors for Long Term Care Facilities
Accessed Online 2/8/2014

Using a “Best Practice” Clinical Practice Guideline
Revised in 2010

(AMDA)
“Altered Nutritional Status in the Long-Term Care Setting”

AMDA – Dedicated to Long Term Care Medicine (AMDA), the professional association of medical directors, attending physicians, and others practicing in the long term care continuum, is dedicated to excellence in patient care and provides education, advocacy, information, and professional development to promote the delivery of quality long term care medicine.

www.amda.com
Altered Nutritional Status (ANS): Unintended and unexpected change in weight that is likely to indicate an undesired alteration in intake or utilization of nutrients.

CPG Guidelines (27 steps):
- **RECOGNITION** – Steps 1 - 3
- **ASSESSMENT** – Steps 4 - 14
- **TREATMENT** – Steps 15 - 22
- **MONITORING** – Steps 23 - 27

Definition of Altered Nutritional Status (ANS): **Unintended and unexpected change** in weight that is likely to indicate an undesired alteration in intake or utilization of nutrients.

Note: Differentiate Protein-Energy Undernutrition (PEU), Cachexia, and Sarcopenia from Altered Nutritional Status (ANS). (Although these may present as ANS)
CHARACTERISTICS RECOMMENDED FOR THE IDENTIFICATION AND DOCUMENTATION OF ADULT MALNUTRITION (UNDERNUTRITION)

The Academy of Nutrition and Dietetics (Academy) and the American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.) recommend that a standardized set of diagnostic characteristics be used to identify and document adult malnutrition in routine clinical practice. An etiologically based diagnostic nomenclature that incorporates a current understanding of the role of the inflammatory response on malnutrition’s incidence, progression, and resolution was proposed.


Dining Practice Standards & CMS Support

www.pioneernetwork.net
Why were Dining Standards created?

Food and Dining are core components of quality of life and quality of care.

How are we currently doing?
- Food consumption
- Supplement Usage
- Weight loss
- Malnutrition
- Customer Satisfaction

Why were these standards created?

1. **Food consumption**: 50-70% of residents leave 25% or more of their food uneaten
2. **Supplement Usage**: 60-80% of residents have an order for a dietary supplement
3. **Weight loss**: 25% of residents experienced weight loss when research staff conducted standardized weighing procedures over time
4. **Malnutrition/Under-nutrition**: 23-85% prevalence
Why?- continued

4. Food and Dining: Integral part of individualized care and self-directed living
   - Food and dining requirements are complex when advancing models of culture change
   - Food and dining are significant elements of daily living
   - CMS receives more questions and concerns focused on dining and food policies in nursing homes than any other area.

Food and Dining Clinical Standards Task Force

This task force was comprised of:
- symposium experts and national standard setting (from many different organizations)
- Goal: “Establish nationally agreed upon new standards of practice supporting individualized care and self-directed living versus traditional diagnosis-focused treatment.”
Who supports the standards?

- American Association for Long Term Care Nursing (AALTCN)
- American Association of Nurse Assessment Coordination (AANAC)
- Academy of Nutrition and Dietetics (formerly American Dietetic Association (ADA))
- American Medical Directors Association (AMDA)
- American Occupational Therapy Association (AOTA)
- American Society of Consultant Pharmacists (ASCP)
- American Speech-Language-Hearing Association (ASHA)
- Association of Nutrition and Foodservice Professionals (ANFP)
- Gerontological Advanced Practice Nurses Association (GAPNA)
- Hartford Institute for Geriatric Nursing (HIGN)
- National Association of Directors of Nursing Administration in Long Term Care (NADONA/LTC)
- National Gerontological Nursing Association (NGNA)

Representatives from Centers for Medicare & Medicaid Services Division of Nursing Homes, the US Food & Drug Administrators & the Centers for Disease Control & Prevention

The Dining Practice Standards Document

Includes the following new Standards of Practice:

1. Individualized Nutrition Approaches/Diet Liberalization
2. Diabetic/Calorie Controlled Diet
3. Low Sodium Diet
4. Cardiac Diet
5. Altered Consistency Diet
6. Tube Feeding
7. Real Food First
8. Honoring Choices
9. Shifting Traditional Professional Control to Support Self-Directed Living
10. New Negative Outcome Focus

* Issued by the Pioneer Network Sept. 7, 2011

www.pionneernetwork.net
The STANDARDS

NOTE:
• Focuses on **ELDERLY** population in LTC facilities
• However, the document’s overarching theme is the support of individualized care and of resident’s choice, which applies to all age groups.

Food & Nutrition is more than monitoring weight. It is a vital part of daily quality of life.
Information Only: New Dining Standards of Practice Resources are Available

Summary:
New Dining Practice Standards
Expanding Diet Options for Older Individuals
Surveyor Training Video:

An interdisciplinary task force, composed of national clinical organizations that set standards of practice, has released a document expanding diet options for older adults. This task force included 22 organizations representing clinical professions involved in developing diet orders and providing food service (including physicians, nurses, occupational and physical therapists, pharmacists, dietitians, among others). The task force formed in 2011 as a recommendation from the 2010 CMS/Pioneer Network commitment on food and dining. The participating organizations include CMS, the Food and Drug Administration, and the Centers for Disease Control.

Research has revealed limited benefit in many older individuals with chronic conditions from restrictions in dietary sugar and sodium, as well as little benefit from tube feedings, parenteral diets, and thickened liquids. The new standards recommended by clinicians and prescribers that a regular diet become the default with only a small number of individuals needing restrictions.

Wounds
PRESSURE SORES & NUTRITION F314 SOM

§483.25(c) Pressure Sores

Based on the comprehensive Assessment of a resident, the facility must ensure that:

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual’s clinical condition demonstrates that they were unavoidable; and

(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

Source: State Operations Manual
Appendix PP - Guidance to Surveyors for Long Term Care Facilities
Accessed Online 2/8/2014

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PRESSURE SORES & NUTRITION F314 SOM

Intent: (F314) 42 CFR 483.25(c)

The intent of this requirement is that the resident does not develop pressure ulcers unless clinically unavoidable and that the facility provides care and services to:

- Promote the prevention of pressure ulcer development;
- Promote the healing of pressure ulcers that are present (including prevention of infection to the extent possible); and
- Prevent development of additional pressure ulcers.

Source: State Operations Manual
Appendix PP - Guidance to Surveyors for Long Term Care Facilities
Accessed Online 2/8/2014
UNDER-NUTRITION AND HYDRATION DEFICITS F314 SOM

Adequate nutrition and hydration are essential for overall functioning. Nutrition provides vital energy and building blocks for all of the body’s structures and processes. Any organ or body system may require additional energy or structural materials for repair or function.

The skin is the body’s largest organ system. It may affect, and be affected by, other body processes and organs. Skin condition reflects overall body function; skin breakdown may be the most visible evidence of a general catabolic state.

Source: State Operations Manual
Appendix PP - Guidance to Surveyors for Long Term Care Facilities
Accessed Online 2/8/2014)

The Role of Nutrition in Pressure Ulcer Prevention and Treatment: NPUAP

- Early nutrition screening and assessment
- Energy
- Protein
- Fluids
- Vitamins/Minerals
- AA:Arginine-Glutamine; Micronutrients: Vitamin C/Zinc/Copper

NPUAP WHITE PAPER
WWW.NPUAP.ORG
NUTRITION/WOUNDS/HYDRATION

Hydration

FLUID/HYDRATION F327 SOM

§483.25(j) Hydration. The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health

Intent §483.25(j)

The intent of this regulation is to assure that the resident receives sufficient amount of fluids based on individual needs to prevent dehydration.

Interpretive Guidelines §483.25(j)

"Sufficient fluid" means the amount of fluid needed to prevent dehydration (output of fluids far exceeds fluid intake) and maintain health. The amount needed is specific for each resident, and fluctuates as the resident's condition fluctuates (e.g., increase fluids if resident has fever or diarrhea).

Source: State Operations Manual
Appendix PP - Guidance to Surveyors for Long Term Care Facilities
Accessed Online 28 2014)
HYDRATION F327 SOM

Risk factors for the resident becoming dehydrated are:

- Coma/decreased sensorium;
- Fluid loss and increased fluid needs (e.g., diarrhea, fever, uncontrolled diabetes);
- Fluid restriction secondary to renal dialysis;
- Functional impairments that make it difficult to drink, reach fluids, or communicate fluid needs (e.g., aphasia);
- Dementia in which resident forgets to drink or forgets how to drink;
- Refusal of fluids; and
- Did the MDS trigger any CAAs for dehydration? What action was taken based on this information?

Source: State Operations Manual
Appendix PP - Guidance to Surveyors for Long Term Care Facilities
Accessed Online 2/8/2014

DETERMINING BASELINE DAILY FLUIDS

- A general guideline for determining baseline daily fluids needs is to multiply the resident’s body weight in kg times 30cc (2.2 lbs = 1kg),
- except for residents with renal or cardiac distress. An excess of fluids can be detrimental for these residents. (1)
- Other Factors to Consider (2)

F327 HYDRATION: SOM

Probes: §483.25(j)

Do sampled residents show clinical signs of possible insufficient fluid intake (e.g., dry skin and mucous membranes, cracked lips, poor skin turgor, thirst, fever), abnormal laboratory values (e.g., elevated hemoglobin and hematocrit, potassium, chloride, sodium, albumin, transferrin, blood urea nitrogen (BUN), or urine specific gravity)?

Has the facility provided residents with adequate fluid intake to maintain proper hydration and health? If not:
- Did the facility identify any factors that put the resident at risk of dehydration?
- What care did the facility provide to reduce those risk factors and ensure adequate fluid intake (e.g., keep fluids next to the resident at all times and assisting or cuing the resident to drink)? Is staff aware of need for maintaining adequate fluid intake?
- If adequate fluid intake is difficult to maintain, have alternative treatment approaches been developed, attempt to increase fluid intake by the use of popsicles, gelatin, and other similar non-liquid foods?

Source: State Operations Manual
Appendix PP - Guidance to Surveyors for Long Term Care Facilities
Accessed Online 28 2014

Dehydration and Fluid Maintenance

There is no universally accepted definition of dehydration

Several parameters used to suspect or define this condition have limitations.

Confusion over the definition of dehydration results in confusion about the clinical diagnosis of dehydration in the long-term care (LTC) setting.

Dehydration may be inappropriately used as a nonspecific generic term referring to derangement in any fluid compartment. Practitioners often use the term dehydration when they mean intravascular volume depletion.

Furthermore, a diagnosis of dehydration may be inappropriately used as a medical reason for hospitalization when the diagnosis has resulted primarily from social considerations.

At hospital admission, many older people who are diagnosed as dehydrated do not meet any accepted diagnostic criteria.

CONFUSION OVER DEHYDRATION DEFINITION
WWW.AMDA.COM
Dehydration refers to a complex condition resulting in a loss of total body water—with or without salt—at a rate greater than the body can replace it. Dehydration is one form of fluid/electrolyte imbalance.

A fluid/electrolyte imbalance is defined as an insufficiency or excess of either water or electrolytes (sodium and potassium) in certain body areas.

WHY FOCUS ON NUTRITION?

Malnutrition is a major contributor to:
• increased morbidity and mortality,
• decreased function and quality of life,
• increased frequency and length of hospital stay, and
• higher health care costs.
I. Know what "Best Practice" is for LTC

II. Facility Team Management

III. Facility Systems and Processes

Food & Nutrition is more than monitoring weight. It is a vital part of daily quality of life.
Choice of food has a tremendous impact on quality of life. Some might say it defines quality of life.

“Best Practice” + Informed Choice and Options = Positive Outcomes

Thank You!

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