



The Dining Experience



Background: In moving from Institutional to Individualized Care many homes identify their dining program and structure to be in need of drastic change in order to better serve residents choice, enjoyment and sense of home and community. This key area of nursing home life can either provide a lovely and much anticipated experience that by nature supports a sense of community, and is at the heart of the rhythm of daily life *or* an environment straight out of a cowboy western with a chuck wagon “head ‘em up and move ‘em out” mentality.

Typical Issues: Nursing homes that felt the need to transform their food and dining programs did so after much study and deliberation. Surveys often revealed an array of complaints from dissatisfied residents, family and staff. Here are a just few. Dining is on a schedule regardless of hunger, want or need. The use of trays and institutional place settings and covers provide an aesthetically unappetizing presentation; “feeding” tables are used for the benefit of staff. Centralized dining often creates transportation problems to and from the dining area with an ensuing sense of chaos, dread, noise and disruptions. Centralized dining perpetuates

an institutional model of care with hallmarks that include control of portions, diets and seating outside of the resident’s ability to choose. The dining room can be an unappetizing social and physical environment. Other food-related issues include limited access to food outside of the designated dining times and an unlikely chance that brands and varieties of snacks are those enjoyed at home. Centralized dining is associated with a wide array of complaints including taste, temperature, texture, dining partners, limited choice and logistics.

Barriers: Changing the dining experience can be among the more challenging changes that an organization can undertake. It presents a multi system dilemma. Dining affects almost every system within a nursing home. It is a pivotal point around which many daily events are timed, from activities to med passes. In order to change, it requires enormous buy-in, flexibility and good interdepartmental communication.

Regulatory Support: *OBRA ’87* fully supports this area of change. The regulatory interpretive guidelines for **F240 Quality of Life**, found in *OBRA ’87* states, “*The intention of the quality of life requirements specify the facility’s responsibilities toward creating and sustaining an environment that humanizes and individualizes each resident.*” **F242 Self-Determination and participation**, includes language that gives the resident the right to “*choose activities, schedules, and health care consistent with his or her interests, assessments and plans of care....*” It also provides the resident the right to, “*make choices about aspects of his or her life in the facility that are significant to the resident.*” Providing a dining program that is structured around resident

choice, preferences, and an environment that provides a sense of home/community is clearly supported by these regulatory requirements.

The provision of food in a nursing home is a multi-layered system that can impact all departments. Having a full understanding of all the regulatory requirements for dietary services is a key component to a successful transformation of a dining program that moves away from the traditional institutional model to an individualized model. Some regulatory requirements for dietary services that homes should be aware of to ensure a successful dining program transformation include food temperature requirements and the frequency of meals requirement.

Some nursing homes have voiced food temperature requirements as a barrier to implementing such dining alternatives as buffet style, restaurant style, family style, and open dining. Although it is true that food temperature requirements need to be considered when implementing any dining program, it is possible to readily meet current regulatory requirements and to institute an individualized approach to resident dining. A common misperception is that hot foods must be *maintained* at 140 degrees F after leaving the kitchen (such as in family style dining when there maybe bowls of food placed on a table for residents to share from.) The regulatory requirement, **F371- §483.35(i) Sanitary Conditions**, for food temperatures includes:

*“Hot foods which are potentially hazardous should **leave** the kitchen (or steam table) above 140 degrees F and cold foods at or below 41 degrees F...”*

The intent of this requirement is that potentially hazardous foods are served at the proper temperatures to minimize the risk for food borne illness. It does **not** require that temperatures be maintained at 140 degrees F after being served.

However, there is another regulatory requirement, **F364 - §483.35(d) Food**, for food temperatures that states:

“Each resident receives and the facility provides food that is palatable, attractive, and at proper temperature.”

The intent of this requirement is that, “...*Food should be palatable, attractive and at the proper temperature as determined by the type of food to ensure resident satisfaction.*” This requirement should not be confused with holding temperatures. Rather, after food leaves the kitchen or steam table (*above 140 degrees F*) it gets to the resident at a temperature that is preferable to the resident (hot foods are served hot and cold foods are served cold). Obtaining ongoing resident feedback regarding their dining experience is necessary to ensure that food is being provided at satisfactory temperatures.

Another common misperception is the interpretation of **F368 - §483.35(f) Frequency of Meals**. This regulation requires each resident to receive and the facility provide at least three meals daily. It also includes that there must be no more than 14 hours between a substantial evening meal and breakfast the following day. Some providers have interpreted this language to mean that all residents must actually eat promptly by the 14th hour, which makes it difficult to honor a specific resident’s request to refuse a night snack and then sleep late. Based on this interpretation, nursing homes are often hesitant to implement an individualized, resident-centered approach to meal service for fear of being noncompliant with this regulation. However, this interpretation is not necessarily intended by the regulation.

In December 2006, the Centers for Medicare & Medicaid Services (CMS) provided the following language clarification regarding frequency of meals:

*The regulation language is in place to prevent facilities from offering less than 3 meals per day and to prevent facilities from serving supper so early in the afternoon that a significant period of time elapses until residents receive their next meal. The language was not intended to diminish the right of any resident to refuse any particular meal or snack, nor to diminish the right of a resident over their sleeping and waking time. These rights are described at **Tag F242, Self-determination and Participation**. It is correct in assuming that the regulation language at F368 means that the facility must be offering meals and snacks as specified, but that each resident maintains the right to refuse the food offered. If surveyors encounter a situation in which a resident or residents are refusing snacks routinely, they would ask the resident(s) the reason for their customary refusal and would continue to investigate this issue only if the resident(s) complains about the food items provided. If a resident is sleeping late and misses breakfast, surveyors would want to know if the facility has anything for the resident to eat when they awaken (such as continental breakfast items) if they desire any food before lunchtime begins.*

This clarification clearly promotes a resident's right to choose and to exercise his or her autonomy. It also provides nursing home providers with some assurances that the regulations and regulatory agencies are supportive of individualized, resident-centered care that provides options for resident choice of meal times in conjunction with full accessibility to nourishing snacks. To view the entire CMS clarification go to CMS's website at:

<http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter07-07.pdf>

For examples of homes that have experienced great success in creating change in the dining experience consistent with federal regulations, see the CMS broadcast, "From Institutional to Individualized Care, Part II and Part III"

<http://cms.internetstreaming.com>

Goal : To offer a wide array of opportunity for residents to participate in meal choice, time, dining partners, seating location in order to maximize their enjoyment of mealtimes while enhancing socialization and improving nutrition.

Infrastructure Helpful to Support the

Change: Invite a committed team of individuals including staff, families and elders to begin conversations that identify the current process and begin to create a vision for the changes needed. Because of the complexity and interconnectedness of the dining systems it is imperative that there be existing evidence of good teamwork and interdepartmental communication. These are skills that can be grown using an array of useful resources. If your teams have not quite reached a level of maturity, try something a bit smaller in scale.

Making the Change: There are many ways to undergo the change process. A good start is to think about who can help and to plan in a systematic way the necessary steps. Ensuring that its not a top-down edict but a shared commitment on the part of the community based on need creates a climate ripe for change. A helpful tool can be the Model for Improvement which uses the PDSA Cycle (Plan-Do Study-Act). This is a way to systematically go through a change process in a thoughtful way.

With your committees and groups ask:

1. What are we trying to accomplish?
(Example: Greater choice for residents, a

less institutionalized setting, resident choice of dining time spread out over two hours, less waste, less weight loss?)

Naming and articulating what it is that you are trying to accomplish will help you months from now (when you are in the thick of things!) to remember the original intention of the change.

2. How will we know a change is an improvement? This is the question that begs a measurement response.

(Example: We had low satisfaction in the area of dining and now look! As a result of this change, we have more people than ever coming to dinner in the evening! Nine of our residents have gained a little weight! Our dining room looked like something from a fifties movie. Since we made the change more people come; seventeen people chose peanut butter and jelly for dinner regularly. Now, no one does!)

3. What changes can we make that will result in an improvement?

(Example: Chefs cooking in the dining room; all staff on deck during meals-pouring coffee, talking with folks, creating an environment of enjoyment and caring; three, two hour meal opportunities so residents can eat when they choose, with whom they choose and at a time that matches their former lifestyle.)

Go study your subject-find out what others have done, take a road trip, phone a friend, go to a Pioneer conference, talk with experts-ask others to do the same.

Plan: Each PDSA cycle has an objective and a measure. In this phase, create it.

Do: Activate the plan & collect data using the method the team decided upon to measure your success. As much as possible do this on a small

scale. Don't try the change on the whole home; try it on a few people or a wing, unit or neighborhood. Small is better. You can keep tweaking and adding to your sample as you see success.

Many teams go as far as Plan-Do. Some teams become very involved in the doing but sometimes find themselves in the midst of many failures without knowing what went wrong or why. The process invites the team to study their activity to ensure they are heading in the right direction. Even finding that one is heading in the wrong direction can offer valuable feedback to a committed team. The next step then, is the study phase.

Study: Test the hypothesis out. Stay open to the possibilities. There are many things you might find happen that you didn't expect. Be sure to note these unexpected gains.

Act: Once you have completed the process identified above you have a more complete understanding of the challenge or problem. Now armed with very specific information and data you have three options:

- Adapt the change
- Adopt the change
- Abort the change

This entire process can be done in a very public way by using storyboards to journey the process. Remembering to celebrate the success of the process is an important feature of the story helping staff, families and resident alike to witness the ongoing efforts made to improve the home.

Innovative Change Ideas: Homes that have undergone change in the dining experience:

- Use menus with an array of choices which are served by an army of smartly dressed service staff who are well-schooled in hospitality
- Have moved away from food trucks, and trays and instead, serve or cook in the dining area using grills and steam tables.
- Involve residents in menu planning by developing a council or advisory group (in some cases residents offered recipes of their own)
- Develop snack pantries or snack nooks where healthy options are available 24/7

Resources:

1. B Evans, N Crogan, J Armstrong Shultz. Quality dining in the nursing home: the residents' perspective. J Nutr Elder 2003 Jun; 22(3): 1-16.

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