Q 1: Do resident rights extend to the family? For example, in the severely demented, non-verbal, patient who is unable to chew and is consuming a puree diet without adverse effects and maintaining weight but the family finds the puree diet distasteful and is requesting a regular diet.

**LEGAL PERSPECTIVE:** The issue here is whether the diet is a medical decision. Since the physician would have ordered a pureed diet the person with the authority to make medical decisions would be the one to make the decision. However, that person must take into account what the RESIDENT would want and that the resident is accepting the puree diet without complaint. It would appear from these limited facts that that is what the resident wants.

**REGISTERED DIETITIAN PERSPECTIVE:** Yes, the family has rights depending on the resident’s documented competency levels and the legal POA/HCS status. The facility should evaluate the POA and resident competency levels carefully. The family should be educated on the benefits of the pureed diet versus the regular diet, including weight stability, safety and other factors. The facility should also try to determine the resident’s choice by looking at food consumption levels. The interdisciplinary team should discuss the situation in a team care planning session and document the discussion, family education, decisions and the plan in the medical records and make recommendations to the MD. The diet order must be deferred to the MD for consideration and the facility must follow the diet the MD decided would be appropriate. However, the dietitian and interdisciplinary team should advocate to the MD to accommodate the diet they believe is the resident’s choice. A waiver for the family would be appropriate if they insisted on the regular diet.

Q 2: How do you care for Rehab residents that are much younger than the LTC residents and want the stricter diets?

**ADMINISTRATOR PERSPECTIVE:** The research we presented was on the limitations of therapeutic diets for those in the final years of their lives where only limited or insignificant benefits can be obtained in a couple of years. For someone who is 50, they can make notable improvements in their health in the next 30 years and should be encouraged to modify their dietary intake because it can have a significant effect. Many Rehab residents are in their 60’s or 70’s where some benefits can be achieved if they continue to follow a more restrictive diet. But Rehab also includes those who are in their 80’s and 90’s with a very limited life expectancy and little chance of significant benefit if the diet is started now. There is not one brush to paint all in Rehab. Age, not Rehab vs LTC is the important variable. Rule of thumb: don’t try to start
something new if the benefit is limited and the negatives on quality of life are detrimental to the resident. Treat each person as an individual.

Q 3: The new (4/17/14) ALF rule incorporated the 2010 Dietary Guidelines that recommend 1500 mg sodium for adults 51 years old and older. How do you provide bacon, sausage, ham, corned beef, kosher foods, Oriental style meals, etc. with this low sodium for the regular diet? These foods will exceed the sodium for the day. A 2000 mg (2Gm Sodium) diet would be more liberal! New Dietary Guidelines will be out in 2015.

**REGISTERED DIETITIAN PERSPECTIVE:** The 2010 USDA Dietary Guidelines focus on foods and beverages that help achieve and maintain a healthy weight, promote health, and prevent disease. Over 50% of the NH population is older than 85, with almost 8% of the NH population 95 years of age or older. Both cognitive and functional impairment are common. We are not necessarily preventing chronic disease at this age, but controlling the disease process in a supportive environment. Quality of life is one reason liberalized and individualized diets are recommended for people 65 years of age and older living in LTC. Healthy menus with alternatives must be written & food preferences honored. It is ultimately the resident’s choice as to which food item is selected.

Q 4: I have tried desperately to educate my patients about these changes, however I am met with resistance from nurses and physicians. How do I overcome this obstacle?

**REGISTERED DIETITIAN PERSPECTIVE:** First obtain the support of the Medical Director, DON and Administrator and then educate them and the nurses, personally and individually on the benefits and get their buy-in. Use evidence-based research to educate them regarding the liberalization of diets for older Americans (over 65 years old), for example:

- The Academy of Nutrition & Dietetics
- AMDA Guidelines/research
- Pioneer CMS Network literature

Use full in-services for the entire nursing and rehab departments, social services, DON and nursing, families and the community once the program is approved. Be a partner to the team. Make it a win/win- happy clients, less nursing pass supplements etc. Implement a step by step plan with a timeline in baby steps, walk then run style.

**ADMINISTRATOR PERSPECTIVE:** Nurses and physicians are sometimes stubborn about their beliefs because they are grounded in the scientific knowledge they have learned in the past. Point out the changes in current thinking and give them the research that will form their opinions to be consistent with the new standards. Be a partner and educator, rather than an adversary, and they will gradually become your allies.

**PHYSICIAN PERSPECTIVE:** Since a Med Director is the liaison between the community and the attending physician, it is the Medical Director’s responsibility to implement and coordinate resident care policies. These policies should address provisions that enhance residents’ decision making. The coordination of medical care includes discussing with the attending physician those practices that are inconsistent with current standards of care and provide resources from nationally recognized societies and associations. Communities can use a QAPI approach to have a change in protocol for liberalized diets. The Medical Director could also send letters to all professional health care staff supporting the new Dining Standards.
Q 5: My question relates to the physician order and Health Care Surrogate decisions. For a resident who has been deemed unable to make their own healthcare decisions and has a HCS...If the resident’s Advance Directives do not include diet consistency, and HCS wants the resident to have a regular diet when a pureed diet is ordered, what voice does that HCS have when the physician will not change the diet order because of the risk for aspiration and complications related to such? Can the facility provide the regular diet to the resident based on the HCS’s wishes?

LEGAL PERSPECTIVE: See answer above regarding the legal authority of the substitute decision maker in making dietary decisions which are also medical decisions. The facility is put in a bind in this situation because the physician is not following the dictates of the HCS. And there may be reasons to justify his refusal. Assuming everyone had adequate information regarding the resident’s condition, wishes and the benefits and consequences of each approach, the next step would be to get the medical director involved and have a meeting with the HCS, representative of the facility, the medical director and the attending physician. If there is still no resolution, the HCS may want to assist the resident or health care decision maker to seek another physician more willing to accommodate the HSC’s requests. If no resolution can be reached and the facility is torn between a physician’s order and a family member’s refusal to let staff honor it, this may be a case for a judge to decide under the Probate Code Rule 9.50. The facility is in a no-win situation.

PHYSICIAN PERSPECTIVE: See answer above regarding physicians’ refusal to liberalize diets. The Medical Director should discuss with all the physicians the right of resident preferences for restricted diets. An important change in the wording and intent addressing resident rights occurred with the revision of F 325-Nutritional Status-Surveyor Interpretive Guidance, implemented 9/1/08. This regulatory intent was changed to emphasize, as part of the assessment, the resident’s preference. The new intent stated: “Provides a therapeutic diet that takes into account the resident’s clinical condition, and preferences, when there is a nutritional indication.”

Q 6: How do we cover education on all possible outcomes of failure to comply with a restricted diet?

PHYSICIAN AND REGISTERED DIETITIAN PERSPECTIVE: The RD and team members will need to prepare risk analysis education protocols for each type of restricted diet and common diagnoses, as well as regular diets. For example: CHF- No Added Salt diet ordered by MD, resident wants regular. Excessive sodium intake may promote or exacerbate fluid overload in residents with CHF.

If someone fails to comply with a restricted diet, doesn’t that mean they don’t want to be restricted? If the restriction is validated with a medical necessity, than the Benefits & Risks of a Regular Diet should be explained to the resident: The emphasis of education would be specific to the medical necessity. Using CHF- No Added Salt as an example:

**Benefits of Regular Diet:**
- Allowed to freely choose whatever foods and fluids are being offered to provide eating pleasure and preserve quality of life
- Might Increase PO intake with outcomes of maintaining adequate nutrition status
- Might lessen chance of weight loss; muscle loss and bone body mass loss; dehydration, UTI episodes

**Risks of Regular Diet:**
- Excessive sodium intake might have outcomes of increased blood pressure; exacerbate fluid overload; edema
- Excessive sodium intake might increases chance of stroke, heart attack, kidney failure

**Alternatives of a Regular Diet:**
- Perhaps resident agrees to eliminate breakfast meats (bacon and ham) to replace the salt he/she wants to use for his/her eggs
- Perhaps resident will try to reduce high sodium snacks (potato chips)
- Adjust medication per MD orders to treat the CHF

**Q 7:** What if the doctor refuses to change the order? I know the resident has the right to refuse, but does the facility have the authority to defy the physicians order and provide the resident desired diet?

**LEGAL PERSPECTIVE:** See the answer above. The only real difference is that the resident has stronger evidence for pushing to have his rights protected. It is imperative that the resident understand the benefits and consequences of his decision. If he is still adamant, there may be a need for him to consult with another potential attending physician. The meeting discussed above is still a good idea. However a 9.50 hearing would not be available. The facility would again be in a no-win situation because of the need to protect the resident’s rights and the requirement to carry out doctor’s orders. When the resident refused a specific meal you would have to notify the doctor of a failure to accept the therapeutic diet but this could become an everyday occurrence and that just would not work over the long term. Call that medical director - he should be right in the middle of this.

**REGISTERED DIETITIAN PERSPECTIVE:** See the answer above. Ultimately we have to follow all MD orders. We must explain and document the benefits and pros/cons to the resident and make recommendations to the MD if the resident continues to refuse the restrictive diet. If the MD refuses to change the diet order, consult the Medical Director. The family may need to seek another attending.

**Q 8:** If all residents are on a NCS diet would you consider giving them all regular diets to keep them from cheating?

**REGISTERED DIETITIAN PERSPECTIVE:** Yes. The new Dining Standards of Practice state to begin with a Regular diet. That should be the ‘norm’ in Long Term Care settings. Restrict concentrated sugar if medically needed, but medication should be used first to control blood sugar. If the resident desires diabetic desserts and sugar substitutions, these should be provided to the resident. Some residents may choose to stay on a RCS or controlled carbohydrate or a calorie count diet. Unless the resident requests, NCS diets should not be provided as they do not meet the standard of care.

*It is recommended that residents be provided diets based on their choices after education, providing the MD will change the diet order. Address their needs individually and develop a plan of care.*
Q 9: What if the substitute decision maker clearly does not take into consideration the resident’s desires (i.e. the resident is obese but is looking for more food and decision maker insists on caloric restriction for weight loss)?

LEGAL PERSPECTIVE: The first step here is to determine why the resident is looking for more food. Is the food that is being given not sufficient to meet his needs? This is a situation that needs the involvement of the whole care planning team and face to face consultation with the family. The attending and the medical director should be involved. A lot depends on the status of the resident - if losing weight is not going to significantly impact longevity but wanting more food enhances the resident’s quality of life that is a factor that must be considered. This is the kind of situation in which there is no black and white. Compromise and creativity are usually the answer. The substitute decision maker must always take into account the resident’s wishes.

REGISTERED DIETITIAN PERSPECTIVE: After nutrition and education, if the resident’s behavior indicates they want more food and they are competent mentally, we should allow more food. Perhaps a compromise to provide healthy choices would be an option and a win/win for all. The MD and RD should offer education.

Q 10: How do you educate a resident that has dementia and wants to consume a food item that places them at risk of choking or aspiration?

ADMINISTRATOR & REGISTERED DIETITIAN PERSPECTIVE: Several things can be done. The first and most important is close observation by the staff while such foods are being given. Having staff available in case there is an issue will help families feel more comfortable. Of course discussing quality of life issues with the family is important. Often they get focused on “extending” life without regard for the quality of that life. In addition, foods that might lead to choking or aspiration can be presented to the resident and then cut into small pieces during mealtime (not before). This way the presentation is more normal, but a safer consistency can be achieved. Finally, seek alternative foods that the resident also likes, but are safer, so they can still enjoy what they like.

DISCLAIMER: The comments above are based on the individual commentator’s interpretation of the question. If the facts were changed even slightly, the comments given could change significantly. Nothing herein constitutes professional advice and, under any individual set of circumstances, you should consult a professional physician, attorney, Registered Dietician or Licensed Administrator. No one reading these comments should take any action based on the comments. Florida Health Care Association does not endorse any information given in response to these questions.