PLANETREE

Open Dining Resource and Implementation Guide

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Table of Contents

Introduction

Long-term care communities have a long history of institutionalized dining characterized by rigid and limited meal times and choices. This Open Dining Guide was developed by Planetree International to support organizations in assessing how resident-centered their approach to open dining ***really*** is, and to identify opportunities for better aligning structures, practices, and culture around the open dining process more generally.

The process to implementing open dining is not linear. In long-term care we often hear the adage, ***"if you change dining, you change everything."*** As your organization implements open dining, you will discover a ripple effect of its impact on other areas within your organization and aspects of residents' quality of life. You will need to circle back and re-evaluate policies, practices, and culture in these other areas because open dining *will* change everything. Some areas to consider are: sleep and wake times, staff schedules, medication times and traditional recreation times. All of these areas, and more, are impacted by the historical dining schedule.

Many organizations implement aspects of culture change and increase the number of choices that residents are able to make, but steer clear of making any real change in dining, such as supporting residents in choosing their meal times. It is impossible to truly embrace culture change in long-term care when residents' lives are organized around rigid meal times, trays are delivered to sleeping residents, and residents are woken for meals.

This tool is designed for organizations that are ready to change. Because changes to dining *does* change everything, this process manual is designed to involve all members of the long-term care community. Changes to dining cannot occur in isolation or just among dining or culinary staff. It involves a true interdisciplinary focus – a focus that includes perspectives from the viewpoints of residents and their families. We are delighted that you have chosen to take this important step. Welcome to the table!

Looking for more support in implementing open dining?

This guide is intended to get you started. You may discover that your organization requires more support. Planetree offers a range of on-site coaching and training opportunities to support your organization in implementing patient and family engagement strategies. Our Experience Advisors will partner with you to develop and implement a customized implementation plan. For more information, contact Jim Kinsey, Planetree's Director of Member Experience, at 203-732-1365 or jkinsey@planetree.org.

Defining Open Dining

Simply put, open dining is a lifestyle right. The general premise can be described as: *"I have a meal when I am ready to enjoy it."* Contrast this to the more common practice in long-term care communities, described as, *"I have a meal because you {the organization} is ready for me to have it."*

In communities with open dining, residents have the flexibility to choose what they want to eat, when they want to eat it and who they would like to eat with. These opportunities reinforce residents taking a proactive and lead role in their lives and self-care, placing the resident at the center of his or her world, rather than the organization's time frames, tasks, and work flows at the center of the resident's world.

Preserving dignity through open dining means that we, the organization, are preserving routines of elders to the fullest capacity. It is no longer enough to provide a compliant dining experience, but to provide one that elicits memories, preferences, and communal engagement. These are the hallmarks of a transformed community that is seeking to fulfill each individual life. While we may not be able to replace a resident's home, we can provide the essence of home – feeling loved, safe, included, and in control.

Open dining can also be defined as*:*

> *"…no one wakes you up, you sleep until you naturally rouse. You decide if you want a cup of coffee, tea or your drink of choice now or later. Maybe you have a coffee pot in your room.If you live in a neighborhood or household, coffee is brewing in the kitchenette or kitchen. You drink out of your own ceramic coffee cup…When you're ready, someone asks you what you're hungry for. Whether you eat breakfast early, late or not at all, but are hungry for lunch a little earlier than most, open dining times make it possible to eat when you are ready." (Bowmen, 2010)*

Each community, in collaboration with staff, residents and family members, should determine what their vision of open dining is. Some questions to consider when determining this vision are:

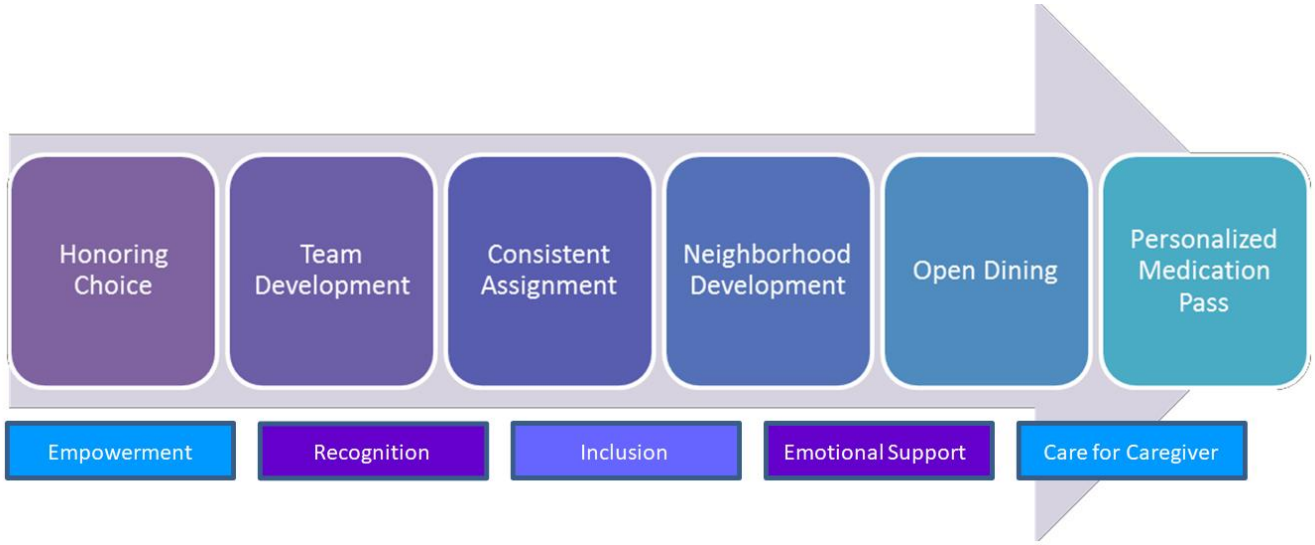
- What is most important to our residents? Timing, availability, access, variety?
- Does open mean everything all the time or is it more aligned with social norms related to dining?
- How will we honor residents who want a more liberalized diet than what is ordered?

- Do we consider a regular diet for all residents and make consistency adaptations as needed?
- How will we define success? What are we measuring to define success?
- How do the least empowered residents, those with significant cognition and/or physical challenges experience their meals? Are their ways to improve their dining experience?

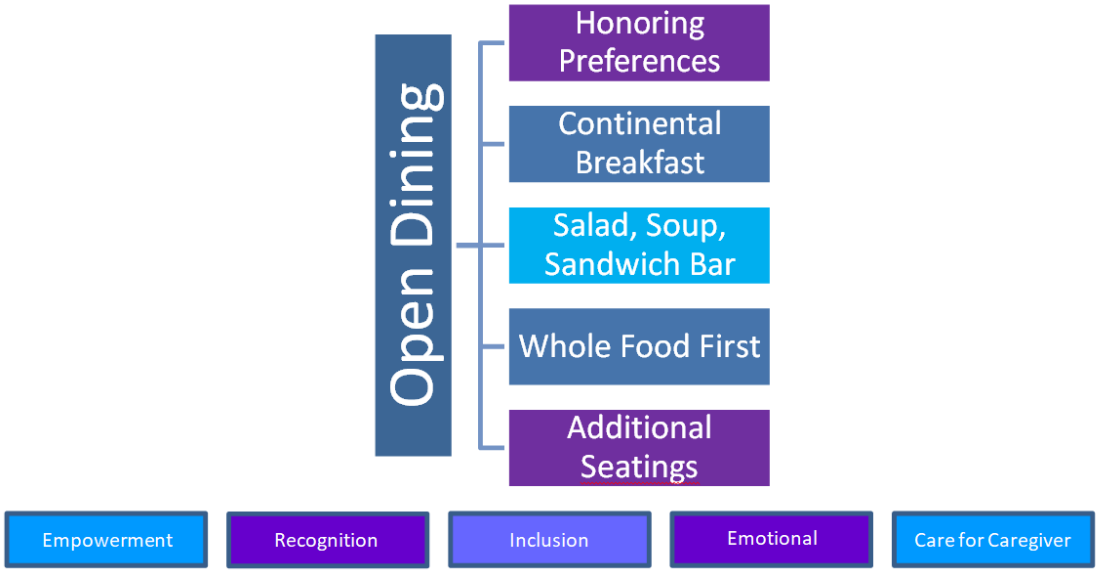
Having a documented vision that can easily be articulated will add to the buy-in of staff members and other stakeholders. It is important that this vision be directly tied to the overall vision of cultural transformation to avoid the perception that this is a new "program" and not part of an overall goal.

Goal Setting and Alignment

Successful goal achievement is often dependent on the goal setting and the connection one goal has to the next. Cultural transformation is not unlike other large scale goals; in order for success to be realized it has to be broken down into smaller individual goals that will lead to success. The diagram below illustrates how the large goal of transformation can be broken down to smaller more achievable goals:



Goals for transformation should be continually grounded in work that cares for the staff and residents alike. Concepts and programs such as care for the caregiver, recognition, emotional support, empowerment and inclusive decision making. Each one of the goals leading to transformation can be further developed into smaller, more achievable goals. Illustrated below is how one community may choose to scale the open dining goal:



The Language of Open Dining

In culture change literature, it is well known and documented that words matter. For example, calling residents "feeders or feeds," is a derogatory term that reduces people to the type of assistance they require, rather than a human being who needs assistance. Other references such as, "he is a therapeutic," medicalizes meals into organizational jargon and dehumanizes the human being who is hungry and preparing to eat a meal.

Another example is to consider the use of the term "alternate" in meals outside of an institution. Rarely in our lives or dining experiences do we refer to menu items at home or in restaurants as "alternates." For example, saying there is an entrée and an alternate may create a process in which a resident who wants the alternate is afraid of making someone go to extra efforts to provide "the alternate." Present the options, as two choices, rather than one choice and an alternate.

In implementing open dining in your community, avoid organizational jargon in the "launch" of your open dining program. For example, avoid telling residents, staff, and families that you are "going live with open dining on May 20th." Instead, announce the grand opening of your restaurant; new menu; etc.

Re-evaluate the terms used to describe staff as well. For example, rather than having dietary staff, consider other terms, such as "chef," "culinary services," "culinary arts," or "food arts." These terms convey a sense of hospitality, hosting, careful preparation, and a certain level of training, more so than the description "director of dietary services" conveys. Further, long held power struggles between dietary and nursing can be eliminated when the words used to describe the departments are re-branded. The feelings that fueled behaviors can change.

Language is one of the foundational elements necessary to support the concept of open and more flexible dining, in addition to other transformative practices. For some organizations, it can be tempting to skip this step and rush to quickly change policies and practices around dining in the attempt to quickly *see* change. This would be a mistake.

Research indicates that for change to truly be effective, it must be routed in the feelings of those who are expected to change. That is, attitudes and beliefs that influence behavior must be addressed first before the behavior can change. *Words create worlds.*

The language used in an organization shapes its world of policies, practices, and culture. What words create your world?

A Case Study in the Language of Open Dining

Long-term care communities often have good intentions when it comes to quality improvement in dining for residents. In a continuing care community, for example, staff members were happy to share advances they had made in reducing the use of commercial supplements given to residents in place of smoothies made with real fruit. Staff brought the blender, used to make the smoothies, to resident areas and used whole frozen fruit in the recipe. They invited residents to press the button on the blender and were overall very proud of the way things were going…except that…residents weren't drinking the smoothies.

During a visit to this continuing care community, Planetree team members noticed that residents were being served their fruit smoothies in the same blue plastic cup that was used in medication administration. *"It's a four ounce cup, so that worked out well for the smoothies,"* said a staff member.

However, in residents' minds, the blue cup was associated with being given medication, and so drinking a smoothie from that cup did not have the appeal that staff were hoping for. Planetree team members also noticed an additional flaw in the well-intended process in that staff were instructing residents to *"take your smoothie."* The cup and the language used in the new dining program were having the reverse effect of what was intended.

Outside of a nursing home, a fruit smoothie is generally thought of as a refreshing treat. It would be very unlikely that we would urge a friend to "take a smoothie," in the same way we would urge them to "*take their medicine"* and then pass them the blue cup used for taking medication. It was no wonder that residents were not as enthusiastic about the smoothies as the staff!

With changes to the language used in inviting residents to enjoy a fruit smoothie and offering the smoothie in a different cup, the program to reduce the use of commercial nutritional supplements and replace them with real food was a success.

The Language of Open Dining: Team Activities

- Share the YouTube video titled, "Change your words, change your world," at the end of your resident's council, family nights, and staff meetings to help explain the decision to change "dining" language in your community.

  (https://www.youtube.com/watch?v=8n4DyFh9iWA**)**

  Debrief questions: *Can you see the relationship between calling someone a "therapeutic or feed" and the impact it has on his/her world? What words do you use to create your world?*

- Check in with members of your community. Have an honest discussion about the words you use to create your "dining" world. What words would you like to keep? What words need to change?

- Take a look at the job descriptions for culinary services in your community. What language is used to convey requirements and expectations of the job? What type of dining experience for residents is conveyed in the language of the ad? How does the language represent your community goals for open dining?

From Kitchen to Table

With increasing attention on the quality of food we consume and the distance food must travel from its original origins to our plates, we've all heard the terms, "farm-to-table, plow-to-fork," etc. The general idea is that the fewer hand offs of food during transit – the closer the point of production, preparation, and service of food is to the person who will eat it – the better. The same principles can be applied in long-term care communities.

Bringing food closer to the point of service is an important aspect of open dining. When food is prepared at home, the preparation area and the dining table are in close proximity. Bringing the point of service for meals closer to the resident supports safer food handling and fewer sanitation risks from mismanaged food temperature control during transit and after delivery (Gaines, 2006). As an at-risk population, older adults are more likely to suffer devastating complications from a foodborne illness. Open dining has the potential to reduce a foodborne illness outbreak because it decreases the number of handoffs during the transit and serving of food.

Traditionally, food service staff members deliver food to the floor and then return to the kitchen, leaving other staff members – commonly nurse assistants (often not trained in food safety) – to manage the food distribution. An open dining approach eliminates the fragmented and potentially risky process of meal service in nursing homes. In addition to the contamination risks of having food sit in a hallway and in spaces dedicated to providing healthcare, in institutional settings, dining trays sit on carts until the nurse assistants have time to distribute them making temperature control virtually impossible.

To improve the dining process to be more flexible and open, you must follow the journey of your food from the kitchen to the table (or resident room). **What hand offs could be eliminated to keep the food "local" – that is as fresh and least contaminated as possible?**

From Kitchen to Table: Team Activities

- Follow your food from kitchen to table. For example, if meals are delivered on trays, set a timer on the meal cart and start it immediately after the last tray is loaded. Then, proceed with meal distribution as normal. Note how long the timer indicates it takes for all trays to be delivered. Take the temperature of the food on the last tray served as a means of understanding how that process of food delivery impacts quality and resident enjoyment of meals. Are cold items cold? Are hot items, including beverages, hot? What is the quality of the food? For example, has the toast steamed under the metal plate cover and become soggy?

- Evaluate the hand-offs of food in your community. Is the process of serving meals fragmented and siloed or a collaborative process? How close is your point of service to the resident? Are there toasters, for example, in the dining room at breakfast? Bring the point of service closer to improve quality and experience.

- What needs to change in your organizational policies to support open dining? For example, are all staff required to receive training in ServSafe during orientation? Do medication administration policies need to be written differently (i.e. upon rising) to support residents' rights to sleep in, rather than being woken for breakfast? Does staff scheduling need to change in order to meet the goal your community has for more open/flexible dining?

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Open Dining Self-Assessment: How Close Are You *Really?*

The grid below identifies 35 aspects of open dining. Review each item and rate your organization on the frequency that particular aspect of open dining occurs. To tabulate your rating:

- Give yourself 2 points if you can answer "ALWAYS" to the item
- Give yourself 1 point if you can answer "SOMETIMES" to the item
- Give yourself 0-points if you answer "NEVER" to the item

Maximum Score: 70 points

Review the scoring legend below for next steps based on your self-reported current state.

Residents sleep in and are not woken up to eat	Residents eat when they are hungry	Use of whole foods; Foods made from scratch	No commercial supplements	Evaluation of medication timing & impact on appetite
Residents make informed choices	Resident choice of food takes priority over what diagnosis warrants	Less Medicalized Wording	Residents are able to host guests at meals	Residents have the right to refuse food items
Residents have the right to ask for smaller portions	Noise is reduced in dining room to promote interaction	Pleasant aromas	Increase selection of foods based on resident preferences	Residents can linger over meals without being rushed
Amount of wasted food is reduced	Residents participate in the routines related to dining: preparing, cooking, etc.	Fresh food is served-no processed or prepackaged	Cold food is not microwaved	Residents have access to drinks & snacks for guests
Residents can store favorite foods & cold drinks	Food storage & cabinetry is visually appealing and non-institutional	All staff is trained in food safety	Residents & Families participate in menu planning	Seating arrangements are flexible
Residents are not left in dining room to wait for meal	Unwritten rules about "no toileting during meal times" are abolished	Self-service food items are available	Meal orders are taken in real-time	The kitchen is equipped to handle short-order cooking
Culinary staff is educated on their role as healers	Residents & staff can eat together for a more natural experience	Service delivery is seamless, rather than fragmented	The point of service is close to the resident	Residents who need assistance eating have choices and variety

Scoring Legend:

- **60-70 points:** Identify stretch goals for continued success
- **59-40 points:** Meaningful progress underway. Choose the next goal from those items scored as a 1 or 0.
- **39-20 points:** Some progress. Time to consider the next level of open dining.
- **Less than 20 points:** Haven't yet considered a transformed dining concept. Start with stating a vision.

Looking at Dining Processes through Fresh Eyes: Team Activities

The following section of the Open Dining Guide is designed to encourage participation and active discussion about common dining pitfalls in long-term care communities. These activities can be used and should be used with diverse groups of stakeholders including residents and families. Encourage role-play and the adaptation of the scenario to your particular organization.

Debrief with members of your community after reading each scenario.

Scenario 1: The Conversation

The following is an expert from a conversation with a "Director of Dietary" *{the department name is purposefully not updated}* in a community with a more traditional/institutional approach to dining about how resident preferences for some aspects of dining are identified and honored.

Interviewer: "As part of resident-centered care, identifying and honoring residents' preferences is important. Can you tell me how you go about finding out what residents like to eat?"
Director of Dietary: "We go around after admission and get the resident or his family to tell us what he likes to eat. Then it goes onto the meal card and we keep that in the kitchen."
Interviewer: "I see. How often are those preferences re-assessed? Daily? Monthly?"
Director of Dietary: "We don't go around to each resident again after that initial assessment, but if they don't like something, we hear about it and we mark the change on the meal card. Sometimes staff forgets to mark it on the card and that can be frustrating, but we get so busy in the kitchen. It's up to nursing to tell the dietary staff if a resident makes a change and then the dietary staff updates the card that we keep in the kitchen."
Interviewer: "That sounds like a lot of work. Do you find that the meal cards work to keep track of who likes what to eat?"
Director of Dietary: "Not really. People forget to update the cards and then we don't look at the cards every day. We rely on staff to know who likes what."

Scenario 1: Debrief

This conversation has several examples where the process of creating flexible and open dining in the community is off to a bad start. For example, residents are asked what they like to eat before they have really had a chance to really experience the food in the long-term care community. A resident could say, for example, that they love green beans and have an image of fresh green beans sautéed in olive oil with salt and pepper until they are just fork tender. When the resident is served green beans in long-term care, however, she may find that the green beans are soft, unsalted, and from a can.

> ***"I wish I hadn't said that I like green beans when they asked me what my favorite food was,"*** a resident said. ***"Now, I get green beans at every meal and I hate green beans. I mentioned it during the resident council meeting, but I could tell that the activity director just thought it was background noise about the food. You can't please every person with every meal you cook. So, I still get green beans. {Sigh}."***

The second process issue is that residents' preferences are not reassessed at some regular and frequent time interval. Ideally, residents would be asked what they are in the mood to eat at each meal. In the above example, there is no forum, other than the resident council meeting, which is often only attended by recreation or social services staff–another flaw in the process- for the resident to voice her preference. Her comments about her dislike of green beans during residents' council meetings are viewed as general complaint about the food and may not get passed on as a specific request for change to the kitchen for that particular resident. Although the activity staff take meeting notes, they are not read by leaders in other departments. With meals being a source of comfort in our daily ritual, being served foods that you dislike can quickly become a pathway to weight loss, depression, and a general lack of personhood.

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Scenario 2: The Conversation

Interviewer: "How do you choose what you want to eat?"
Resident 1: "We have a fella that comes around every week and asks us to circle what we want from the two choices on the menu. You usually choose on Monday for the week. It is hard for me to remember what I chose by the time Friday comes around. And it makes it hard to change your mind. Sometimes, I just circle whatever. How do I know what "Chicken Chantilly" is? I can't see it. Is it lemon chicken? Or does it have tomatoes? I just try to be easy going."
Interviewer: "How do you choose what you want to eat?"
Resident 2: "The waitresses come around to our rooms in the morning and tell us what the entrée is for the day and what the alternate is. We tell them what we want to eat for lunch and supper. I ask for half portions because I get this big plate of food. It's too much. I feel wasteful when they take most of it away, uneaten."

Scenario 2: Debrief

What is the current process for taking meal orders in your community? How can you get closer to taking orders in real-time, at the time of meals, when residents, who are eating because they are hungry – not because it is "time" can use the aroma and sight of food to make their selection? Are samples of plated food ever shown to residents to help them make their selection? How are residents supported in making choices about smaller portions and second helpings?

Who does the current process for taking meal orders really serve? For example, asking residents to choose their food for the week is not for their benefit since our preferences for foods can be influenced by our emotions, aromas, physical health, etc., at any given moment. Making choices that far in advance is really for benefit of the organization, not the resident.

As mentioned earlier in this guide, consider the use of the term "alternate" in meals outside of an institution. Rarely in our lives or dining experiences do we refer to menu items at home or in restaurants as "alternates." Eliminate the use of the word "alternate" in the language of choices. For example, saying there is an entrée and an alternate may create a process in which a resident who wants the alternate is afraid of making someone go to extra efforts to provide "the alternate." Present the options, as two choices, rather than one choice and an alternate.

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Scenario 3: The Conversation

Interviewer: "How do residents choose what they want to eat?"
Staff Member: "We choose for them. We know what they like. Most of the ones in this unit can't say what they want to eat or even remember to eat, so we make sure we order for them."
Interviewer: "How do you choose what you want to eat?"
Resident 1: "I just get whatever they are offering for the day. I really miss bacon though. Aw man. See, I eat a puree diet, so all my food is chopped up. I don't think I need that, but the doctor does. If you eat the puree diet, you have to eat what they give you. You don't get the same choices."

Scenario 3: Debrief

In scenario 3, we see examples of residents' worlds and their ability to make choices being reduced. In scenario 3, it assumed that residents living with dementia are not able to make choices about the types of foods they would like for meals or the timing of the meals. Research indicates that this line of thinking is common in long-term care and is also found to be untrue. Persons living with dementia are able to make choices related to dining. In long-term care, unfortunately, it is often the residents who require more care that have fewer choices. In evaluating your dining program, consider the question: Is flexible dining equally available to all residents? What assumptions are we making about residents that are not able to verbally communicate preferences for foods, meal times, and waking/sleep times? Are residents with "mechanical diets" offered the same range of choices as residents who eat a "regular" diet?

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Scenario 4: The Conversation

Interviewer: "How do you incorporate resident-centered care into the dining experience here?
Director of Dietary: "We had this resident that had on her meal card scrambled eggs. Her tray went up for breakfast with scrambled eggs on it like always. Then I got a call from the nurse that she didn't want scrambled eggs and was asked if I could poach an egg for her. I snapped a little at the nurse because she didn't seem to understand that I was in the middle of something. She doesn't know what working in the kitchen is like. I made the poached egg, but it took me a while because I had to get started on lunch prep. They don't realize that wanting a different kind of egg really puts me out in the kitchen. I took it up there to her and she was grateful. Then, no sooner had I gotten back downstairs, I got a call that she wanted hot sauce. So, I had to make an extra trip up to her room. It took me at least five minutes to catch the elevator and get it to her. By then her egg was cold. We were both frustrated. That's a lot of extra work for one resident, but I did it because we are resident-centered. The nurse should have told me when they asked for the egg that she wanted hot sauce."

Scenario 4: Debrief

This scenario demonstrates a common misconception about what resident-centered care really is. For example, being resident-centered does not mean that an organization will go out of the way, even when it is inconvenient to the work process, as in the above example, to accommodate it when and if a resident makes a choice about their meal that deviates from normal. ***Authentic resident-centered means that the opportunities for residents to make choices are the norm, not the exception that needs to be accommodated.***

With the point of service being so far away from residents, meals are plated and placed on trays down in the kitchen and then sent up on meal carts for distribution. Because identifying a resident's food preference is only done once on admission, the resident receives the same scrambled egg for breakfast every day. When understandably, her need for variety arises, a lengthy chain of events occurs which ultimately disrupts resident satisfaction with the meal experience and preparations for the next meal in the kitchen. For the staff member, the extra work to prepare the egg, the stress of changing tasks in the kitchen, the frustration with his colleague in nursing, and the time spent delivering the egg and the sauce are a wasted effort because ultimately, the resident receives an egg that gets cold as she waits for hot sauce. In addition, her coffee was delivered with her original tray and is now cold. For the resident, asking for a different egg meant that she had a breakfast of a cold poached egg, cold toast, and cold coffee.

Communities that approach resident-centered care by maintaining institutionalized dining while trying to accommodate special request meal changes on a case-by-case basis, like the one in the example above, often have good intentions, but miss the mark.

When residents want second helpings or extra sauce, such as the hot sauce for the egg in the above example, staff often report many wasted steps and time as they search for the items or telephone special requests to the kitchen. Outside of institutional dining setting, it is not unusual to be in a restaurant and ask for more bread, dipping sauce, and/or a different type of beverage, etc. Ensuring that these items, which are anticipated requests in most dining experiences, are as close to the point of service as possible is key to a seamless and dignified dining process.

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Scenario 5: The Conversation

Interviewer: "How would you describe your role in the dining experience?"
Director of Nursing: "We get an admission in the middle of dinner. We call the kitchen to order a tray and the kitchen will bite your head off."

Scenario 5: Debrief

Think back to video "Change your language, change your world," shared earlier in this guide. It's very different to say. *"We need a tray for a new admission on unit 3"* versus *"Sam is new here. He just arrived and he is hungry for his first meal from our community. What can we prepare for him as a welcome?"*

The Director of Nursing in this example describes her role in dining as limited. She places an order to the kitchen. How can all employees share in the dining experience? What could the nurse have done to orient the new resident to the options for dining? How does the language that she uses, telling the resident, for example, "I will call down and get you a tray," create a world of experience for the resident? A tray is not food. It is a not something we typically eat on at home. It is characteristic of institutions. For a new resident, hearing that they will receive "a tray" tells them nothing about the food they will enjoy. In fact, it tells them they will most likely not enjoy it. "A tray," doesn't convey comfort or something to look forward to. Imagine if the nurse had said, "We have a crockpot of homemade soup today. Would that taste good to you?" or "We have so many good choices on the menu today. Let me tell you what they are so you can choose." Even better, imagine if she could offer a beverage and small snack to tide the

new resident over until his meal arrived. Instead of saying that she "had an admission," she could have conducted the required admission assessments while welcoming and hosting the new resident. It is typical to offer a guest in our homes something to eat or drink. How are staff supported in being able to do this? Once established, how are residents supported to offer their guests drinks or snacks?

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Scenario 6: The Conversation

Interviewer: "What's the food like here?"
Family Member: "I think they try. They really do. But, I see my dad's food come in on this drab tray and it makes me sad to see that it looks so blah. There is a beige plate with beige chicken and mashed potatoes and brown gravy and white-gray cabbage. And it is all beige. Nothing about the presentation gets him really excited to eat or explore what is on his tray. If I help get him started, then he will eat pretty well. But, when I am not here, I am not sure someone gets him going. And, like I said, the food doesn't really draw him in on its own."

Scenario 6: Debrief

Choose a week and take pictures of the meals that are served in your community. Do not limit yourself to meals served only in the dining room. Post the pictures in the staff lounge for feedback. Share the photos in resident council meetings and at family night. Ask everyone to look at the photo and imagine, "eating with their eyes first." What feedback do they have on the presentation of the food (colors, portions, texture, serve ware, etc.)? Use the feedback to make adjustments, if needed and/or celebrate a job well done. Also evaluate the process of serving, opening containers, offering condiments, refreshing beverages, assisting with cutting foods if requested, when food is served in resident rooms. How are residents who eat in their rooms approached for warming up coffee, refreshing a beverage, second helpings, and/or condiments?

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Scenario 7: The Conversation

Interviewer: "What's it like to eat in the dining room?"
Resident: "The waiters and waitresses look great in their new uniforms. They have new menus for us to use. It is more like a real restaurant experience now than it used to be. But, I've noticed that the wait staff just reaches across you to clear the table. They also rush you and tell you to hurry because they have to do the dishes and leave by 7pm. I don't like being rushed.

Scenario 7: Debrief

Food is an important component of healing, comfort, celebration, and bereavement in many areas of life. Within long-term care communities, however, food not only provides residents sustenance and nourishment, but also comfort, pleasure, a sense of routine and socialization. Because culinary staff members are central to one of the daily experiences that residents' often look forward to the most, they need to be coached on their role as healers within the organization. Food must be seen as more than just a tray that needs to be passed or work tasks associated with distributing and cleaning before and after meals. Staff appreciation for culinary staff is critical in retaining your work force in, what is typically, a high turnover position. Also important is ensuring that staff meets behavioral expectations when interacting with residents during the dining experience. How do you coach staff about their role as healers within the organization? How are staff recognized and rewarded? How can staff schedules be adjusted so as to not rush residents to finish their meals?

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Scenario 8: The Conversation

Interviewer: "What's it like to eat in the dining room?"
Resident: "I've asked for nibbles while we wait for the meal. Some bread. Some crackers. But, I am told no. You can't even get a cup of coffee. We are wheeled in the dining room almost an hour before the meal starts and then we have to watch as some people eat sooner. You can smell the food. So you just get hungrier as you sit there. They say it is like a restaurant, but there isn't food to nibble on while you wait and the room is just silent. It's not really like a restaurant where people serve you as soon as you sit at the table. There isn't a rush to interact with you."

Scenario 8: Debrief

Imagine being seated at a restaurant table for one and one-half hours before your meal is served. Outside of an "institution" this would be considered a low quality dining experience. In fact, most of us would get up and leave. Because most residents cannot leave, however, understanding their experience as they wait for their meal requires both empathy and a desire to improve the process from their perspective. When the process is evaluated mainly from the perspective of work tasks, staffing, etc., the resident and family perspective of the experience becomes secondary. Try secret shopping the dining experience. That is, go to the dining room before the dining hour. See what the experience is like. How long does it take for meals to be served? What is the temperature? How is social interaction promoted while residents wait for the meal to arrive? What is the presentation of the food like? Is it dignified? Does it align with the residents' expectations? How could it be better? How can it be more restaurant-like? Assign various people to "secret-shop" the dining experience at different times. Do the food and the environment feel healing? Does it feel nurturing?

***

Scenario 9: The Conversation

Interviewer: "What's it like to eat in the dining room?"
Resident: "Actually, I eat in my room. I used to eat in the dining room, but I have a very sensitive stomach, so I usually need to go to the bathroom during dinner. I would ask the staff and they told me that they can't leave the dining room during dinner. I had an embarrassing accident. It was a mess. I just decided ever since then that I would eat in my room."

Scenario 9: Debrief

Research indicates the negative impact the unwritten rule of no toileting during meal times has on residents (Hung & Chaudhury, 2011). Are there any (un)written rules about what's "allowed" during the meal time? Be honest. Get as many perspectives as you can.

***

Scenario 10: The Conversation

Interviewer: "What's the "always available menu?"
Resident: "Actually, I have never heard of that before, if there was one it may be easier to get what I want. I will ask for other options and it is seen as a bother by the girls. They aren't exactly nice about special request."

Scenario 10: Debrief

Many long-term care communities offer an "always available" menu, especially for patients who are in the community for short-term rehabilitation. There are a variety of ways to improve the work design of making "always available" items truly "always available." For example, in some communities, this menu is often not available to long-term residents, residents are unaware that the menu exists, and residents and staff describe the "always available" choices as putting a strain on the kitchen. The need to redesign job roles to accommodate the short-order cooking style that coincides with offering more choices is essential. Staffing patterns that are flexible and overlapping tend to work best with offering this type of meal selection. Consistent assignment of staff to take orders, prepare, and deliver the food items is also essential to the menu's success. Streamlining the process of ordering and having the equipment necessary for short-order cooking to take place is essential. For example, if the stove only has a limited number of burners and those are occupied with preparations for the next meal, then a call for a grilled cheese from the always available menu results in either waiting or staff having to remove an item from the stove burner so they can make a grilled cheese. In order for the open dining program to be successful, the kitchen must have the needed equipment and tools. Conduct an environmental audit and make an itemized list of needed items/equipment. Provide that list to leadership, including corporate staff to ensure that there is financial support to acquire the items.

Debunking Excuses and Fears

Excuses, challenges, and fears are all a normal part of change and the process of implementing something new. The following statements are examples of common excuses used to avoid changes to dining.

"Our residents love the food here. If we change the routine that they are used to, then they will be mad. We have specific times for meals, but the residents are actually hungry at those times so the schedule works."

"We have assigned seats in the dining room, but the residents like it. If someone sits in their seat by mistake then they let that person know. They would not like it if we stopped assigning seats."

"The residents ask to get up in time for breakfast because they don't want to miss it."

"Some residents can't make decisions about what they want to eat."

These excuses, undoubtedly, contain some truth. That is, over a period of time, residents' hunger cycles are likely to have adapted to when meals are available. Some residents are likely to find comfort in having the same seat at each meal. It may appear that some residents with verbal or cognitive challenges can't express a choice. It may be true that residents ask to be on the morning "get-up" list.

However, it is important to remember that institutionalized people rarely know they are. It would be like asking a fish, "How is the water?" To which the fish would reply, "What water?" Residents may indicate that they are happy with the current dining process in the community because they do not realize that there is a universe of other possibilities for how they could make choices about meals. For many residents, they have grown comfortable in the routine that the organization created because they were never offered the chance to create their own routine based on their hunger cycles, their biorhythms, and their preferences.

Some residents will welcome the idea of change, while others will likely worry about changing their established routine. This is to be expected. Remember, open dining is part of an organization's long game. Current residents in long-term care communities are primarily of an age cohort associated with growing up during the Great Depression and associated with traits such as not challenging authority, accepting what is offered, and not wasting food. The

dynamics of future age cohorts, combined with changes in expectations and a greater range of choice for healthcare consumers, makes it likely that, "*customers, savvy and well educated, will re-formulate long term care by demanding fine dining, and concierge services, and healthy fast foods from a food court with 'brand' named franchises open 24 hours per day*" (Robinson and Gallagher, 2008).

Enhancing Dignity by Preserving Routines

Previously in this guide we made reference to the need for residents to experience a life that is respectful of their life history, routines and preferences. Preserving routines can be a challenge, however what is clear is that residents who experience a preservation of routine have a more vital, life affirming experience. To put it more succinctly, as one resident said, ***"I get to be me, and that is what matters most!"***

Preserving routines related to food are as important as rhythm of life routines. Consider all the group and individual activities that surround dining and food. There is preparation for the meal: setting the table, clearing the table, placing linens on the table. There is the actual food preparation: cutting, chopping, cooking, and baking. Socially there is conversation, discussing ingredients, identifying recipes and connecting with culture. These are all vital routines that as we transform our cultures and dining we must find a path to identify ways to preserve these routines; these routines make up the dining ***experience***!

Many communities that have transformed their dining have included these routines as stretch goals for their program. Stretch goals are those that will elevate a good practice to great – a goal that may be a bit of a challenge to attain, but building on the foundation of a solid program is certainly obtainable. It must be emphasized that the inclusion of residents in these activities should be at their choice and, in some areas, care planned as their choice to participate.

To prepare for these stretch goals have your task force consider the following:

- How do residents currently participate in the preparation of the dining rooms?
- Do residents, when asked, desire to have their recipes integrated into the menu?
- How are residents involved with cooking? This goes beyond traditional passive participation in activities that involve food. In those activities often the food is whisked away to be cooked and then later appears in its final form. When considering the preservation of routines, go beyond this passive participation to actual cooking.
- Are resident gardens tended to by residents and is the food grown used within the organization for meals?
- How are conversations initiated in the dining room? Are there conversation cards on the tables, is there a program on the radio or TV of the residents choosing?
- How is every resident included in the experience? How are life histories and known routines of those living with dementia integrated into the experience?

11 Essential Steps to Open Dining

STEP 1 **Do your research.**	Read up on other organizations' efforts to implement open dining. If you are a Planetree member, mine the sample policies available through My Planetree (myplanetree.org). Consult with your Resident and Family Partnership Council to explore your residents' and family members' experiences with dining. Take the pulse of staff (through an informal focus group, quick home-grown survey, etc.) to gauge current attitudes and potential concerns about implementing open dining.
STEP 2 **Establish a vision and goals.**	As mentioned previously in this guide, this is often a missed opportunity for organizations. Being able to communicate who, what, where and, most importantly, the why is essential for buy in for stakeholders.
STEP 3 **Educate residents, family, staff, physicians, and corporate leaders.**	Provide education to everyone in the community about why open dining is important. Be proactive about addressing any common concerns/fears that arise.
STEP 4 **Identify physician, pharmacy, and nursing champions.**	This team will need to evaluate medication administration orders in your community to support your open dining program (please see appendix for examples). This could include consideration of how certain medications impact weight and appetite, as well as, rewriting existing medication orders to be delivered "upon rising" to eliminate residents being woken for a meal.
STEP 5 **Form a multidisciplinary task force to lead the charge.**	Select a group of champions to lead the charge in open dining. This team will need to identify challenges to open dining and resolve them. For example, is the kitchen equipped to handle cooking for an "always available" menu? Do staff schedules need to change in order to support this initiative?
STEP 6 **Ensure the environment supports the dining experience.**	Do a facility walk-through, with an eye for the dining experience. Are you providing an environment that is welcoming and home-like? Is there wall pollution (paper signage) that could be removed? Is there comfortable seating? Are utensils, napkins, and dinnerware good quality? Have staff been educated on the service expectations?
STEP 7 **Develop communication materials to notify all community members of the change.**	In conjunction with Step 5 above, partner with community members to create communication materials that describe your open dining program. Set a date for community-wide implementation and share these materials in advance of that date.

STEP 8 **Conduct a small scale test of change.**	Identify a specific area(s) that is willing to pilot open dining for a specified period of time. Before the pilot, collect baseline data on satisfaction, as well as, clinical benchmarks. This small scale test of change pilot, could include one area of the community using open dining or a pilot to add additional flexibility to your existing dining experience, such as self-service food items, continental breakfast, etc.
STEP 9 **Establish a time frame for community-wide implementation and finalize open dining practices and policies.**	Drawing on the experience of this open dining guide, the multidisciplinary task force refines the practice, develops appropriate policies, and educates other departments. Use newsletters, communication boards, etc. to share the results of the open dining pilot and generate support for moving forward with community-wide implementation. Set a date and stick to it. Ask the task force to provide support and coaching before, during, and after the community-wide change to open dining.
STEP 10 **Publicly recognize your champions for their participation as change makers.**	Publicly recognize staff who have supported this resident-centered practice. Celebrate your progress as a community. Publically share your open dining program with local press, state agencies and surveyors, as well as, national associations in long-term care.
STEP 11 **Monitor and measure to hardwire the practice.**	Monitor the spirit and intent of your open dining program to avoid possibility of "institutional creep," setting back in (ie- unwritten "get-up" lists, making choices for residents rather than residents choosing, etc.). At appropriate time intervals (6 months and a year), compare your baseline data against your current satisfaction and clinical data. What does the data tell you about what impact the open dining program is having? Ensure that open dining remains hardwired by including ongoing training to all staff and orienting new staff to the practice during their onboarding process.

Additional Resources:

Long-Term Care Improvement Guide

A free download available at www.residentcenteredcare.org

Planetree, Inc. is a mission based not-for-profit organization that partners with healthcare organizations around the world and across the care continuum to transform how care is delivered. Powered by focus groups with more than 50,000 patients, families, and staff, and more than 40 years of experience working with healthcare organizations, Planetree is uniquely positioned to represent the patient voice and advance how professional caregivers engage with patients and families. Guided by a foundation in 10 components of patient-centered care, Planetree informs policy at a national level, aligns strategies at a system level, guides implementation of care delivery practices at an organizational level, and facilitates compassionate human interactions at a deeply personal level. Our philosophical conviction that patient-centered care is the "right thing to do" is supported by a structured process that enables sustainable change.

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Appendix A

Sample Policies to Support Open Dining

(From Heritage Place, Soldotna Alaska)

central peninsula hospital
heritage place

Title: Choice Dining Plan

I. Purpose:

To ensure and encourage independence, choice, socialization, and offer flexibility for each resident by adjusting meal serving times to meet the resident's sleeping patterns.

To promote care in a manner and in an environment that maintains or enhances each resident's dignity and respect.

To provide each resident with a nutritional, palatable, well-balanced diet that meets the special dietary needs of each resident. And to assure that the resident receives adequate and frequent meals.

To help ensure that the resident maintains acceptable parameters of nutritional status, such as body weight, protein levels, proper hydration and health.

II. Policy/Procedure/Intervention:

Meals and snacks will be offered on a schedule provided below. The menu will be planned using a variety of foods with reference to the USDA "Food Guide Pyramid", the Food and Nutrition Board National Academy of Sciences RDAs, the Council of Nutrition, the American Dietetic Association, and the University of Pittsburgh Medical Centers Liberalized Diet. Meals will be individualized to meet each resident's preferences, needs, and daily schedule.

Approximate serving times:

Breakfast Buffet	7:00 a.m. to 10:30 a.m. Soup and
Salad Bar	10:30 a.m. to 6:00 p.m. Lunch
	10:30 a.m. to 2:00 p.m. Afternoon
Snack	2:00 p.m. to 4:00 p.m. Dinner
	4:00 p.m. to 6:00 p.m. Bedtime
Snack	7:00 p.m. to 9:00 p.m.

A large, morning brunch and a large evening meal will be served daily by nutritional staff. The brunch and evening meal will be served in the resident dining area by use of steam table service and in the Sitka Rose neighborhood by hot-holding-transport-compartment service or by tray service to another appropriate area of resident's choice.

Three additional food offerings will be prepared daily by nutritional services and served in the dining room or delivered to each neighborhood via a serving cart by nutrition and/or wellness staff: Sitka Rose staff will provided these three additional food offerings from their daily pre-stocked nutritional cache.

A breakfast buffet will be offered to residents upon rising. If a resident wishes to sleep late in the morning he/she can still eat breakfast. In Sitka Rose some type of breakfast will be available for them upon waking. This may include but not limited to: fresh fruit, canned fruit, yogurts, toast, muffins, or other bread items, hot cereal, scrambled eggs , milk, juice, coffee or beverage of choice

An early afternoon hydration and nutritional snack cart will be delivered primarily by the nutritional staff. This snack may include but not limited to: fresh fruit, canned fruit, puddings, yogurts, bread/starch items, finger foods, sandwiches, cheeses, milk, juice, or beverage of choice. Other items offered will be based on resident preferences and may include a hot or cold menu item weekly. Hot soup and Salad Bar are available in dining room from 11am to 6 pm.

A bedtime hydration and nutritional snack from the Resident Kitchen will be passed by the Wellness Staff. This snack may include but not limited to: a starch item, one high quality protein item, i.e., meat or cheese sandwich, fruit, puddings, yogurts, milk, juice, or beverage of choice. Other items offered will be based on resident preferences.

Individual packaged snacks and hydration of choice will be available at all times for resident preferences for unscheduled snack needs. This snack cache will be kept in the Resident Kitchen and monitored for inventory and date compliance by the food service staff.

Total hydration and caloric intake will be monitored and charted daily by Wellness and/or Food Service Staff. Any inappropriate intake patterns will be reported to Food Service Management, Dietitian and/or Wellness Nursing staff and documented. See clinical tool assessment triggers.

The resident has the right to refuse food and/or hydration. If the resident refuses his/her breakfast nourishment then the staff should discuss food refusal risk and benefits with the resident (when possible), then follow-up with the resident's family, and resident's' physician to assure that the resident's wishes are being honored. Documentation of the discussion in the resident's record and support the decision that was reached will be made and resident monitored for involuntary weight loss patterns. See clinical tool assessment triggers.

The resident may choose to eat in his/her room versus in the dining room. If this resident does not have an Informed Consent for Diet Choice to ensure the safety of the resident eating unattended in his/her room, wellness staff will accompany this resident while the resident dines in their room until one can be obtained. If the resident does have an Informed Consent for Diet Choice then this resident may dine in their room unattended.

There must be no more than 14 hours between a substantial evening meal and breakfast the following day. When a nourishing snack (consisting of three of the four major food groups) is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident agrees to this meal span. A resident must be offered a nutritional meal following this meal span.

III: DOCUMENTATION (DOCUMENTS AND FORMS):

Assessment Tools:

Clinical Guide to Prevent and Manage Malnutrition in Long-Term Care for Nursing Staff

and Dietary Staff Clinical Guide to Prevent and Manage Malnutrition in Long-Term Care

for Physicians and Pharmacists Liberalized Diet Manual

IV: REFERENCES:

483.10 (Resident's Rights), F150-154, 483.15; (Quality of Life) F240-242; F166, F241, F311, F241; 483.25(i); (Quality of Care/Nutrition) F325-327, 483.35 (Dietary Services) F360, F363, F364-F368

V: OTHER RELATED POLICIES/PROCEDURES:

N:\Support Services\Food Services\Policies and Procedures

central peninsula hospital
heritage place

Title: MEDICATION - ADMINISTRATION

Purpose: **To provide a means to ensure that medications are administered in accordance with state and federal regulations. To provide a means to ensure that resident medications are administered on an individualized schedule, rather than during the traditional meal-time medication pass. To provide a means to ensure that all medications administered are properly documented in the resident's record.**

Policy: It is the policy of this facility that medications be administered as prescribed by the attending physician, and only by persons lawfully authorized to do so. Instead of scheduled administration times set around the traditional meals of breakfast, lunch and dinner, medications will be administered based on the resident's individualized schedule of waking and dining when appropriate. The administering nurse is responsible for documenting all medications given, as well as the circumstances surrounding missed scheduled doses.

Procedure/Intervention(s):

Only licensed medical and nursing personnel or other lawfully authorized staff members may prepare, administer and record medication.

Medications must be administered in accordance with the written orders of the attending physician. (NOTE:
If a dose seems excessive considering the resident's age and condition, or a drug order seems to be unrelated
to the resident's current diagnosis or condition, the nurse should contact the physician).

All current medications are recorded on the resident's electronic Medication Administration Record (eMAR) and must include: name and strength of the drug, dosage and frequency, route of administration, appropriate diagnosis, and date ordered.

PRN medication charting must include time and dosage given if any variability. Documentation must accompany any need for administration and results must be reported in a reasonable fashion. In addition, a PRN pain medication requires a pain assessment and PRN antipsychotics require behavior notes. The electronic record monitors documentation and provides alerts for review.

Identification of the resident must be made prior to administration by comparing with resident's picture in the eMAR. Label on the blister pack must be compared with the notation

in the eMAR for verification. If any discrepancies occur, pharmacy must be notified to bring the label into agreement with the order.

Only the person preparing the resident's medication may administer it.

Medications may not be set up in advance.

Medication ordered for a particular resident may not be administered to

another resident. Unit dosing by means of blister packs will be the

standard practice wherever possible.

When a medication is held or refused, the personnel must document such and note the rationale. When medications are consistently refused both doctor and supervisor must be notified.

To provide a means of ensuring that resident medications are administrated on an individualized schedule, times will revolve around the resident's rising rather than a set time. When medications are ordered more frequently than daily, or are ordered at bedtime rather than rising, the Consulting Pharmacist may be asked to give direction. Every effort will be made to minimize the disruption of the resident's schedule.

Documentation (Documents & Forms):

N:\Wellness\Wellness Forms\Nurses Signature Form for Med Book

N:\Wellness\Wellness Forms\Narcotics Flow Sheet

V. References:

Other Related Policy/Procedures:

N:\Wellness\Wellness Policies\Medication – Self Administration N:\Wellness\Wellness Policies\Medication – Controlled N:\Wellness\Wellness Policies\Medication – Disposition of Controlled N:\Wellness\Wellness Policies\Medication Pass Monitoring N:\Wellness\Wellness Policies\Medication – Ordering N:\Wellness\Wellness Policies\Medication Errors

Title: Informed Consent for RECOMMENDATIONS

Purpose: To provide a means to ensure those residents and/or their families or responsible party are made aware of the risks and benefits when a resident and/or family or responsible party wishes to refuse dietary restrictions or other recommendations ordered

Policy: Refusal to comply with any ordered recommendations will be reviewed at admission and with any new order. These include, but are not limited to: dysphagia recommendation, therapeutic diet, medication order and/or activity order. An Informed Consent for Refusal of Recommended Treatments form will be signed.

Procedure/Intervention(s):

The admitting nurse should discuss dietary restrictions and/or supervised dining compliance during the admission care conference. The MDS nurse is responsible for reviewing compliance with dietary restrictions and/or supervised dining during each care conference. If a dietary and/or supervised dining issue arises between care conferences, the Resident Care Coordinator and/or a staff nurse will address the issue.

The risks and benefits will be noted on the document and the resident/family representative will sign with a witness signature as well. This form is then sent to the physician for informational purposes.

Documentation (Documents & Forms)

N:FORMS\Wellness\Informed Consent V. References:

483.10 (Resident's Rights), F150-154, 483.15; (Quality of Life) F240-242; F166, F241, F311, F241; 483.25(i);
(Quality of Care/Nutrition) F325-327, 483.35 (Dietary Services) F360, F363, F364-F368

VI. Other Related Policy/Procedures

N:\FORMSWellness\Nutrition Resident Choice Dining

INFORMED CONSENT FOR REFUSAL OF

TREATMENTS OR RECOMMENDATIONS

Including but not limited to: Wanderguard, Dysphagia restrictions, Therapeutic diets

Resident's Name _____

I, as Resident and/or Legal Designated Representative:

do not wish to _____

_____;

my wishes are _____

_____.

I have been informed of the medical outcome of not following the above medication and/or treatment recommendations. These outcomes include, but are not limit to:

Risks_____

_____

_____

Benefits _____

_____

_____

_____ _____

Residents or Designated Representative Signature Date

_____ _____

Nurses Signature Date

_____ _____

Physician (used only as information) Date