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MDS Alert

Dining Assessment: Dining Observation Tool Measures Amount, Quality Of ADL Assistance

This approach helps you identify residents at risk for weight loss.

Staffing shortfalls combined with a high number of residents who aren't eating well can add up to a plateful of F tags. But an evidence-based dining observation tool allows you to identify residents who need more staff attention at mealtime -- and to keep your weight-loss QI/QM in the healthy range.

The **Centers for Medicare & Medicaid Services** recently provided Webcast training on the tool, which a facility can use whether it has CNAs or a combination of CNAs and paid feeding assistants helping residents with meals, according to **Thomas Hamilton,** director of the Office of Survey and Certification at CMS.

Supervisory staff use the tool to observe the level and quality of dining assistance, which is the first step to identify areas for quality improvement. The observer doesn't have to be a licensed nursing supervisor, said **Sandra Simmons, PhD**, at **Vanderbilt University**, during the Webcast. Dietary staff, social services, administrators, etc., have also been taught to use the tool.

Focus on Residents at Risk

Start by identifying residents at risk for unintended weight loss so you can use the tool to observe them during mealtime. Those groups include residents who have the following characteristics:

• Recent unintended weight loss or a low body mass index. You can define weight loss based on MDS criteria (a 5 percent or more loss in the last 30 days or 10 percent or more in the last 180 days) coded in Section K, according to Webcast presenter **John Schnelle, PhD**, at **Vanderbilt University**. Or you can identify residents with any unintended weight loss in order to intervene before they shed additional pounds.

• Residents who consistently don't consume enough food and fluids. People who don't eat well are defined as those consuming less than 50 percent of food and fluids offered during most meals, says Schnelle.

• An assessed need for ADL assistance with meals. Published research by Schnelle and Simmons shows that residents with different ADL self-performance scores who are not eating very well require the same amount of ADL assistance (Journal of American Geriatrics Society 2006;54(6)919-924).

"A lot of residents who are physically independent and can eat on their own don't do so," Schnelle tells **Eli.** They have poor appetite for various reasons and require as much staff time to get them to eat an acceptable amount as do residents who are totally physically dependent, Schnelle reports. **Beware:** Residents who have swallowing difficulties may require as much as 35 to 40 minutes of assistance, according to the Webcast.

Recheck ADL eating scores and Section E (mood): Consultant **Sheryl Rosenfield, RN, BC,** believes eating is almost always undercoded on the MDS. Also, any resident who can eat on his own but isn't eating enough should be evaluated for depression, emphasizes Schnelle.

How to Use the Observation Tool

The observer uses the tool to assess whether the resident received physical assistance, verbal instructions and social stimulation from staff during the meal. The tool defines social stimulation by staff as "not specifically directed toward eating" -- for example, comments such as "You look nice today." Reasoning: The vast majority of people usually eat

better if they have social interaction while they eat, the Webcast presenters noted.

The observer checks on the tool whether the resident received more than five minutes of assistance -- or less than five minutes -- and whether the person consumed more or less than 50 percent of the meal. (See the tool on p. 53.)

Research shows that long-stay nursing home residents who need assistance with eating require an average of 20 to 30 minutes to ensure adequate food and fluid consumption, Simmons tells **Eli.** "And our research studies showed that residents either got 15 to 20 minutes of assistance or just meal tray delivery and possibly set up (e.g., cutting up meat)," requiring only a couple of minutes.

"So, for the observational tool, the five-minute mark was a good cut-off because residents who got more than five minutes of assistance received 15 to 20 minutes on average," Simmons says. The five-minute mark also prevents the observer from having to watch every resident for the entire period of time at every meal. If the observer has time, however, he would initially watch a designated number of residents from the beginning to the end of the meal, Simmons advises. That way, the person would "get a really good overall picture of what's going on with the individual residents as well as the overall meal service provided by the facility."

Once the observer familiarizes herself with the residents' eating habits, she could spend just 10 to 15 minutes at the beginning of the meal at the point of meal tray delivery -- and then return for 10 to 15 minutes at the end of the meal to record the data elements on the tool, Simmons says. The observer compares what she has recorded on the tool to medical record documentation about the resident's meal intake, which research shows caregivers tend to overestimate for various reasons.

The person can then use the information to evaluate the quality of dining services overall and for individual residents.

Using a standardized observation tool where you know the amount of time spent, the type of help provided and the resident's response to the help are just a few of the quality measures that you can collect from a brief dining assessment, according to the Webcast. The facility can also train staff to engage in more social interaction with residents during meals and cue and encourage residents to eat. Staff should also offer to get residents an alternative menu item if they aren't eating because they don't like a particular food.

Creative solution: In one facility, it became obvious that the reason direct care staff were hesitant to offer residents alternatives to the served meal was due to the distance between the kitchen and the dining room, Simmons says. The facility addressed this problem by sending a second, smaller cart to the dining room that held 10-15 "extra" meal trays of alternatives, which helped improve residents' meal intake.

More: The interdisciplinary team can also use the tool to implement dietary interventions that will truly help residents improve their food consumption. For details, see the next article.