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MDS Alert

Tool: Need Ideas For Tracking, Tackling The Quality Of Meal-Time Assistance?

CMS Webinar provides these suggestions.

Proactive facilities don't wait for residents to trigger the unintended weight-loss QI to take a look at whether their residents are getting the right kind of ADL help for eating.

In a recent webinar, the **Centers for Medicare & Medicaid Services** suggested facilities could use the following quality measures to monitor and improve various components of the dining experience.

1. Staff ability to get residents out of bed and to the dining room for meals.

Scoring Rule: Score as "fail" if less than half of the resident population, as defined by those residents capable of oral food and fluid intake (exclude residents who are bed-bound, tube-fed and/or on hospice) is eating the meal in the dining room, or other common location. Count all dining rooms and other common eating area(s).

Rationale: Residents eating in the dining room are more likely to receive help to eat from staff, get social interaction during the meal and have accurate documentation of their percent eaten. Residents are often allowed to eat meals in their rooms in bed, not necessarily due to their own preference but because it is easier for staff. Moreover, residents who eat in their beds are often not positioned properly for eating (semi-reclined), which places them at greater risk for choking. Finally, social isolation during meals may contribute to low oral intake and depressive symptoms.

2. Staff ability to provide verbal instruction to residents who receive physical assistance at mealtimes.

Scoring Rule: Score as "fail" any resident who receives physical assistance to eat from staff without also receiving at least one episode of verbal instruction directed toward eating (e.g., "Please try your beans").

Rationale: Graduated prompting protocols using verbal instruction increase residents' independent eating behaviors and oral food and fluid intake. Staff often provides excessive physical assistance to residents who could otherwise eat independently with just verbal instruction. Ideally, the verbal instruction should precede physical assistance to encourage independence in eating, but the scoring rule for this indicator allows staff to "pass" if verbal instruction is provided at any point during the meal (before, during or after physical assistance).

3. Staff ability to provide social interaction to all residents during mealtimes.

Scoring Rule: Score as "fail" any resident who does not receive at least one episode of social interaction (i.e., verbal interaction that does not include a specific instruction to eat, "how are you today?") during the meal.

Rationale: Social interaction has been shown to enhance oral food and fluid intake in residents. Social interaction during meals is also important to residents' quality of life and should not be limited to those with low oral intake.

4. Staff ability to provide adequate feeding assistance to residents who receive an oral liquid nutritional supplement during mealtimes.

Scoring Rule: Score as "fail" any resident who receives an oral liquid nutritional supplement and less than five minutes of staff assistance to eat during the meal.

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Rationale: Oral liquid nutritional supplements are most effective in increasing daily caloric intake when provided between regularly-scheduled meals as opposed to with meals. Supplements are often inappropriately given with meals and may be used as a substitute for quality feeding assistance. Thus, residents should not be given a supplement during the meal unless staff has provided assistance to encourage the resident to eat the served meal.

5. Staff ability to provide assistance to at-risk residents.

Scoring Rule: Score as "fail" any resident who consumes less than 50 percent of the food and fluid items on his or her meal tray based on direct observation and who receives less than five minutes of assistance from staff during the mealtime period.

Rationale: If a resident who consumes less than 50 percent of a meal also receives less than five minutes of feeding assistance from staff, then the staff is providing potentially substandard feeding assistance, failing to recognize an oral intake problem, or both. Residents who receive less than five minutes of assistance typically receive only tray delivery and set-up with no additional help; whereas, those who receive more than five minutes receive, on average, 15 to 20 minutes of staff attention.

6. Staff ability to accurately identify residents with clinically significant low oral food and fluid intake during meals.

Scoring Rule: Score as "fail" any resident who consumes less than 50 percent of the food and fluid items on his or her meal tray based on direct observation but who is identified by staff (i.e., medical record documentation of percentage intake for the same meal as the observation) as consuming equal to or greater than 60 percent.

Rationale: The federal criterion for low oral intake is defined as "leaves 25 percent or more of food uneaten" or consumes less than 75 percent of most meals. Recent evidence, however, suggests that residents who consistently consume less than 50 percent of most meals are at a significantly higher risk for weight loss. Thus, if staff documents that a resident consumed more than 60 percent of a meal when, in fact, the resident ate less than 50 percent, it is likely staff are failing to identify a clinically significant oral intake problem for that resident.

7. Staff ability to offer meal alternatives to residents who do not like the served meal.

Scoring Rule: Score as "fail" any resident who eats less than 50 percent of food and fluid items on his or her meal tray based on direct observation and who is not offered a meal alternative (i.e., substitution) at any point during the meal by any staff member.

Rationale: Residents often do not like the served meal or certain items on the meal tray; however, most residents will not complain directly to staff about the meal service or request something else. Thus, it is important for staff to notice if a resident is not eating well and offer him or her alternatives to the served meal or individual foods or fluids (e.g., sandwich, fruit, orange juice instead of apple juice, sausage instead of bacon).

8. Staff ability to accurately document feeding assistance care provision.

Scoring Rule: Score as "fail" any resident who receives less than five minutes of assistance from staff but who has medical record documentation for the same day and meal that feeding assistance was provided.

Rationale: Studies have shown that feeding assistance is documented in the medical record as provided for all residents at risk for weight loss (those rated on the MDS as requiring assistance to eat and/or those with a history of weight loss), even though most of these residents actually receive less than five minutes of assistance. Thus, medical record documentation related to feeding assistance care provision is not accurate or specific enough to be useful for quality improvement efforts. Supervisory-level staff needs to be aware of the inaccuracy of this documentation to inform improvement efforts.

Source: Handout for the CMS webinar, "How to Enhance the Quality of Dining Assistance in the Nursing Home" (http://cms.internetstreaming.com).

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