



Person Centered Dining Feeding the Body and the Soul

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Food, does anything else matter!

- “All you need is love. But a little chocolate now and then doesn’t hurt either” Charles M. Shultz
- “Seize the moment. Remember all those women on the ‘Titanic’ who waved off the dessert cart.” Erma Bombeck
- “Let food be thy medicine and medicine by thy food” Hippocrates



We all love to eat!

- How are we going to feed the souls of our residents?
- What is most important to them?
- How do we incorporate individual preferences into household life.
- Weighing professional dietary standards with resident choice.
- The environment, where we eat!
- What do we do while we're eating?



New Dining Standards –

- Standard of Practice regarding Diet Liberalization: Diabetic, Low Sodium and Cardiac
- Altered Consistency Diet
- Tube Feeding
- Real Food First
- Honoring Choice
- Shifting from Professional control to self-directed Living
- New negative outcomes



Diet Liberalization

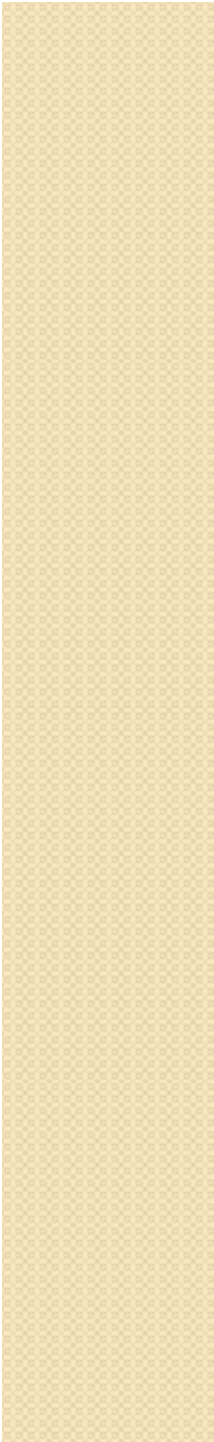
- AMDA says, that weight loss is prevalent in the nursing home and one of the most common reasons are therapeutic diets. To paraphrase, they don't taste good and residents therefore are not inclined to eat the food. They say that the use of therapeutic diets, including low salt, low fat and sugar restricted diets should be minimized in the Nursing home setting. Physicians should be “encouraged to consider liberalizing dietary restrictions that are not essential to the resident well-being”.
- Residents and families used to dietary restrictions at home, may need to be educated about these changes

The ADA, takes the position that the “quality of life and nutritional status of the older person in the long –term care facilities may be enhanced by liberalization of the diet prescription”

“The recent paradigm shift from restrictive institutions to vibrant communities for older adults require dietetic professionals to be open-minded when assessing risks versus benefits of therapeutic diets, especially for frail older adults”.

“Although therapeutic diets are designed to improve health, they may negatively affect the variety and flavor of the food offered”.

The benefits of less-restrictive diets, outweigh the risks !!!



Centers for Medicare and Medicaid Services (CMS)

- Liberalized diets should be the norm
- Adequate nutrition and ideal body weight are best achieved by serving residents “regular or minimally restricted diets”
- Enhances quality of life and nutritional status
- Honor the residents food preferences before adding supplements
- Interdisciplinary team needs to be on top of the need to temporarily remove dietary restrictions if the resident is not eating well.
- The IDT, resident, family and physician must work together when the resident is failing to thrive.



Current thinking

- “A regular or liberalized diet which allows for resident choice is often the preferred initial choice.”
- “persons moving into a nursing home should receive a regular diet unless there is strong medical historical reasons to initiate or continue a restricted diet.”
- IDT should continue to monitor ‘medicalized diets to ensure that they continue to be medically indicated’, such as other medical devices, such as a urinary catheter.



Recommended Course of Practice

- Diet determined with the person, with their informed choice about goals and preferences, rather than exclusively diagnosis!
- Consider beginning with a regular diet and see how the resident does eating it.
- Empower and honor the person.
- A resident may not be able to make decisions about all aspects of their life, but may still be able to make choices about dining
- We still need to monitor the resident related to their nutritional status and their physical, mental and psychosocial wellbeing.
- There is often not one right answer. “Possible interventions have the potential for both help and harm the resident. Resident always has the right to refuse recommended advice and the team must support the person and their decisions.”
- “All decisions default to the person.”



Individualized Diabetic/Calorie Controlled Diet

- AMDA-
 - ‘intensive treatment of DM may not be appropriate for all individuals in the LTC setting. To improve quality of life, diagnostic and therapeutic decisions should take into account the patient’s cognitive and functional status, severity of disease, expressed preferences, and life expectancy.’
 - “An individualized regular diet that is well balanced and contains a variety of foods and a consistent amount of carbohydrates has been shown to be more effective than the typical treatment of diabetes.”

ADA:

- No evidence to support diets such as no concentrated sweets or no sugar added
- These restricted diets are no longer considered appropriate
- Most experts agree that using medication rather than dietary changes can enhance the joy of eating and reduce malnutrition.

CMS:

- Nothing specific about diabetes, but much is stated about liberalizing diets.

Current Thinking

“It may be appropriate in many cases to liberalize the treatment goals or targets rather than add more medications.”

“Only benefit to a sliding scale insulin is with a new dx. When clinician is attempting to estimate a daily dosage of insulin.”

“More than once daily blood sugars in stable diabetic patients should be discouraged.”

Recommended Course of Practice

Diabetic diets are not shown to be effective in the LTC population of elders

Diet is in accordance with the person with his/her informed choices, goals and preferences, rather than exclusively by diagnosis

All decisions default to the person.



Individualized Low Sodium Diet

- **AMDA:**
 - “ Such dietary restrictions may benefit some individuals, but more lenient blood pressure and blood sugar goals in the frail elderly may be desirable while a less palatable restricted may lead to weight loss and it associated complications”.
- **ADA:**
 - The relationship between congestive heart failure, blood pressure and sodium intake in the elderly populations has not been well studied.”
 - A liberal approach to sodium in diets may be needed to maintain adequate nutritional status, especially in frail adults.”

CMS

Dietary restrictions, therapeutic (e.g. low fat or sodium restricted) diets, and mechanically altered diets may help in select situations. At other times, they may impair adequate nutrition and lead to further decline in nutritional status, especially in already undernourished or at-risk individuals.”

CMS, again recommends taking it back to the interdisciplinary team to possibly liberalize the diet temporarily to stabilize the resident’s weight.

Relevant research trends

“Limiting salt intake for residents with CHF is felt to be of benefit in limiting fluid retention, but the clinical experience of two medical director of numerous nursing homes shows show that this is necessary in only a minority of patients.

Older residents still have the same taste preference as they have had all their lives and a low salt diet will not be appetizing.

Please don’t take the salt shaker away from me. I will be bringing my own to the nursing home and by the way, check me for a paring knife!

Recommended Course of Practice

Low sodium diets not effective in the LTC population.

Diet is to be determined with the person and in accordance with his/her informed choices, goals and preferences, rather than exclusively by diagnosis.

Again, unless a medical condition warrants it, start with a regular diet.

Empower and honor the person first, and the whole interdisciplinary team second, to look at concerns and create effective solutions

Support self-direction

Individualize the care plan

All decisions default to the person.



Individualized Cardiac Diet

- AMDA
 - Routine dietary restrictions are usually unnecessary and can be counterproductive in the LTC setting.
 - Special diets for DM, HTN and heart failure have not been shown to improve, control or affect symptoms.
 - Any reason for dietary restrictions should be clearly stated on the patient's record.
- ADA
 - Dash diet- Dietary Approaches to Stop Hypertension is known to reduce blood pressure and may also reduce rates of heart failure. It is low in sodium, saturated fat and high in calcium, magnesium and potassium.
 - The nutrition care plan of LTC residents with cardiac disease should focus on maintaining blood pressure and blood lipid levels while preserving pleasure and quality of life.
- CMS
 - Dietary restrictions may help in select situations. But, again they may impair adequate nutrition and lead to further decline in nutritional status in at risk individuals and a the IDT team is responsible for liberalizing the diet and stabilizing the resident's weight.
- Recommended Course of Practice
 - Low fat diet only have modest effect
 - Diet is to be determined with the person and in accordance with his/her informed choices, goals and preferences, rather than exclusively by diagnosis.
 - Start with a regular diet
 - Get the physician and consultant pharmacist involved.
 - All decisions default to the person



Standard of Practice for Altered Consistency Diet

- **AMDA**

- “Swallowing abnormalities are common, but do not necessarily require modified diet and fluid textures, especially if these restrictions adversely affect food and fluid intake.”
- Residents may reject foods that have been pureed, but readily accept foods that are soft in nature, mashed potatoes, and yogurt.
- Likewise, finely chopping food and using softening agents such as gravy, may be very accepted by the resident.

- **ADA**

- The RD and the SLP should collaborate to modify resident’s diets that they remain palatable. Residents with modified texture diets report increased need for assistance, dissatisfaction with food and decreased enjoyment of eating, resulting in reduced food intake.

- **CMS**

- Take a “holistic approach , look beyond the symptoms to the underlying causes”.
- “Excessive modification of food and fluid consistency may unnecessarily decreasing quality of life and impair nutritional status by affecting appetite and reducing intake.”
- “No interventions consistently prevent aspiration and no tests consistently predict who will develop aspiration pneumonia.”

Relevant Research Trends

- Diseases which affect muscles strength and coordination alter the ability for residents to effectively complete a swallow or protect their airway, resulting in choking or aspiration may result in pneumonia.
- Data on the effectiveness of the use of ground or pureed food and thickened liquids is inconsistent: "not all residents with dysphagia aspirate or choke, and not all aspiration results in pneumonia.
- Improved oral care can reduce risk of developing aspiration pneumonia in the elderly.
- Frazier Water Protocol
- "Management of all geriatric conditions involves some risks. No known evaluations or interventions can guarantee someone will not aspirate."

Current Thinking

- Evaluate the person as a whole, not just as someone with dysphagia. Look at how they are doing "medically, functionally and psychosocially."
- Needing to determine what is best for the residents, a special diet that is not eaten, is not doing anyone any good.



Standard of Practice for Tube Feeding

- **AMDA:**

- May be clinically appropriate in certain circumstances- should not be an automatic step- a decision that needs to be made by fully informed resident, family and the interdisciplinary team.
- “Does not ensure patient’s comfort or reduced suffering.”

- **ADA**

- “Enteral feeding may not be appropriate for terminally ill older adults with advanced disease states, such as terminal dementia, and should be in accordance with advanced directives.?”

- **CMS**

- Take a holistic approach when deciding how to intervene for chewing and swallowing abnormalities.
- Look beyond symptoms to underlying causes.
- “Identification of a swallowing abnormality alone does not necessarily warrant dietary restrictions or food texture modifications.”
- “Tube feeding may be associated with aspiration , and is not necessarily a desirable alternative to allowing oral intake, even if some swallowing abnormalities are present.”

Relevant Research Trends



- “Tube feeding have not been show to reduce the risk of aspiration or prolong survival in residents with end stage dementia.”
- PEG tubes do not improve a resident’s quality of life, deprives them of social experience of mealtime, restricts movement, shows little or no improvement in weight



Recommended Course of Practice

- **The are very good to keep in mind as we navigate the nutrition needs of our residents!**
 - Diet determined with the person, in accordance with their informed choices, goals and preferences, not their diagnosis.
 - Be aware to a resident's preferences in regards to socialization, physical supports, timing of meals and the value of the dining experience.
 - Empower and honor the resident first and secondly the involvement of professionals and the interdisciplinary team.
 - Start with a regular diet
 - No clear answer when caring for frail elderly
 - “Most professional codes of ethics require the professional to support the person/client in making their own decisions, being an active not passive, participant in their care.”
 - Get the physician involved in explaining risks and benefits to the resident and the ID team.
 - Support self-direction and individualize the care plan.

All decisions default to the person





Standard of Practice – Real Food First

- AMDA:
 - Provide foods that are comfortable for residents to chew and swallow, mashed potatoes, yogurt, puddings. Many folks have already switched to softer foods as they've aged. Our residents love soft-cooked eggs, French toast, chopped salads, egg, chicken and tuna salad and homemade soups.



Real foods...

- ADA

- Make the food you are serving as comparable to what the resident is used to at home.
- Lots of choices
- Familiar foods and seasonings
- Not a substitute for the real thing, get the real thing!

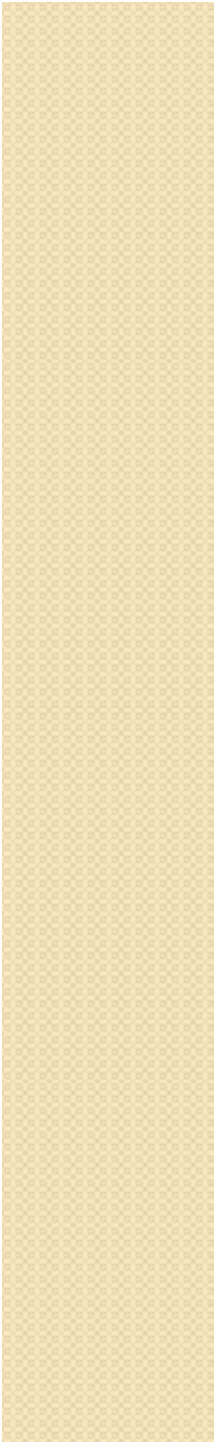
- CMS

- Wholesome fresh foods are preferable to nutritional supplements.

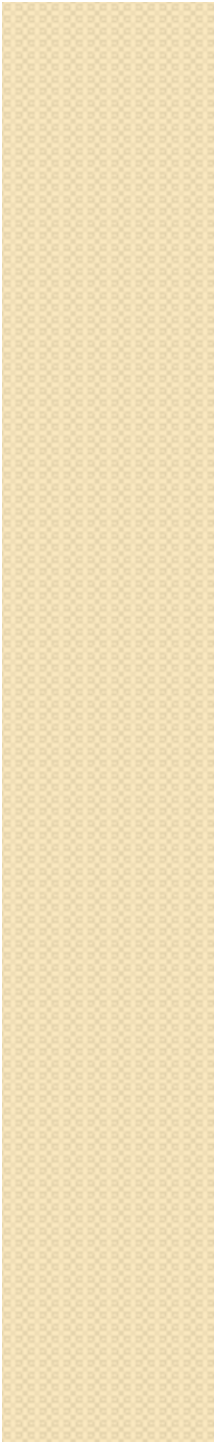


Potluck and food from home...

- Concerns about food from approved sources. F371, says that “food must be procured from approved federal, state and local sources. .prohibits residents from any of the following: 1.) growing their own garden produce and eating it; 2.) eating fish they have caught on a fishing trip or 3.) eating food brought to them by their own family or friends.”



The language is in place to prohibit a facility from getting food from questionable sources, in order to keep residents safe. This would be a problem if the facility were using these sources to supply food for residents, since we would not be able to track to foods sources. But in the case of potlucks and family parties etc. the facility is not procuring the food and the resident is making a choice to eat what they want to eat. It wouldn't be any different if a resident buys a hot dog at the ball park. The right to choice is also part of the regulatory language!



On the concerns about unsafe food sources, such as home prepared or home preserved foods . CMS provided guidance in 2009 that said, “food procurement requirements are not intended to restrict resident choice. All residents have the right to accept food brought to the facility from any visitor(s) for any resident. So allow your residents to enjoy their special foods and treats. I recall a time, about 18 years ago, when my husband’s grandmother was in the nursing home I was the Administrator of, and heavens know we couldn’t make her a dippy egg, so my mother in law would fry Elsie some eggs and rush up to the nursing facility. Sounds ridiculous today! Hopefully this doesn’t have to happen anywhere!



Relevant trends

Choose food before supplement and food before medication- a natural decision in Culture Change.

Reese's peanut butter cups way before supplements

Serving good wholesome food and snacks vs. "passing out Supplements"

Reducing medications may help to improve appetite

Enhance and fortify your foods with butter, cream, sugar

Know the culture of your resident and prepare to their liking. Our residents like oyster stew and sandwiches, pork and sauerkraut, long johns from Achenbach's, fresh asparagus, corn, tomatoes, toasted cheeseburgers and soft pretzels. What do yours enjoy?

Households kitchens make you hungry. The sounds and smells of the kitchens are a wonderful thing. Whether it is the smell of cookies baking, bacon frying or garlic wafting through the halls, it is a lot better than the smells that normally waft through the halls of skilled nursing facilities.

Offer regular coffee and decaffeinated.



- Freezing fresh corn is one of our traditions at GSV. We purchase our corn through approved local farms, have a husking party, cut the corn off the cob and freeze it. Thanksgiving Dinner features our fresh frozen corn. Just like home.



Standard of Practice- Honoring Individual Choice

- We are now offering our residents many more choices than we have in the past and this will only need to deepen.
- Open Dining times, methods of serving, Breakfast at will, availability of many dining venues, accessible snacks and kitchens to prepare food.
- “Honoring choice is born out relationship and consistent resident staff relationships are essential for this.”



Honoring Choices

- ADMA

- Residents will thrive with more choices.
- Team can weight the risks and benefits and develop an individualized care plan.
- Balancing medical complexity with personal choice is “the essence of good medicine”.

- ADA

- “Involving individuals in choices about dining such as food selections, dining locations and meal times can help them maintain a sense of dignity, control and autonomy.”
- Let me make my own decisions and I may eat more.

CMS

CMS:

Tag F242 Self-Determination and participation - The resident has the right to:

1) Choose activities, schedules, and health care consistent with his/her interests, assessments

and plans of care;

2) Interact with members of the community both inside and outside the facility; and

3) Make choices about aspects of his or her life that are significant to the resident.

Providers are to be actively seeking preferences, choice over schedules important to the resident i.e. waking, eating, bathing, retiring and states if resident is unaware of the right to make such choices determine if home has actively sought resident preference information shared with caregivers.⁹³

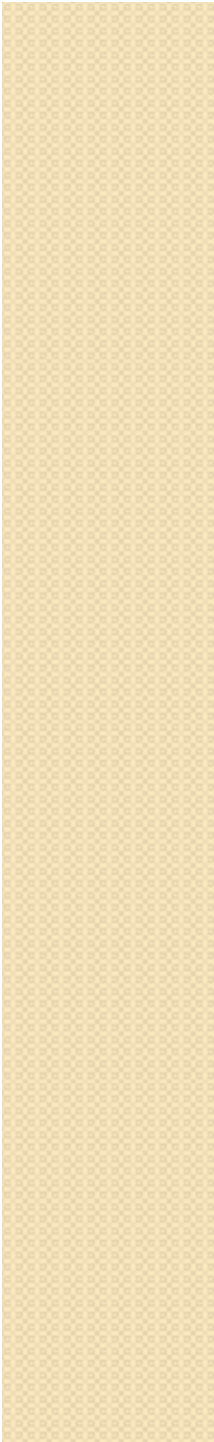
Tag F280 Participation planning care and treatment – The resident has the right to - unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning of care and treatment or changes in care and treatment.

Sometimes, a resident or resident's representative decides to decline medically relevant dietary restrictions. In such circumstances, the resident, facility and practitioner collaborate to identify pertinent alternatives. [The resident or representative] has the right to make informed choices about accepting or declining care and treatment.

Relevant Research Trends



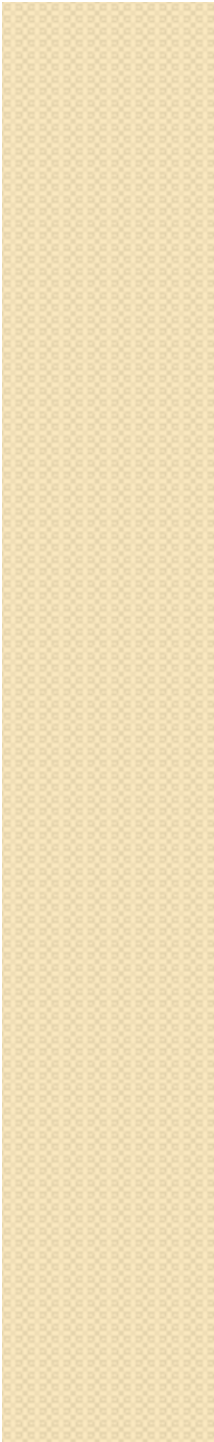
- Our Residents
- Like to snack
- Make choices about everything, including food.
- Choose who they want to sit with
- Like to have food available 24 hours a day!

- 
- Many residents are going to be able to reliably tell you if they like the food or not!
 - “Physician should work closely with the registered dietician, DON, and Food Service Director to develop a system promoting resident choice while maintaining quality of care.”
 - “Make sure residents are informed about dining rights.”
 - Does the resident have a voice in dining choices.
 - Make sure we have educated and informed the resident about alternatives and consequences of choice.
 - Document ..document.. Care Plan.. Care Plan
 - Eleanor’s Pizza on a Snowy Thursday night!



Recommended Course of Action

- “Choices with meaningful options in accordance with the person’s preferences are offered to each resident numerous times daily, i.e. when to awaken, when to eat, what to eat, where to eat, what to do, when to bathe, when to retire, what to wear, etc.
- • A variety and increased number of staff present in the dining room enables both physical and psychosocial needs to be met. Additionally, staff can enhance and honor the individual choices for all residents reflective of preferences.
- Simply speaking, it is all about choice. It is as simple as asking, “What does the resident want? How did they do it at home? How can we do it here?” Choice of what to eat, when to eat, where to eat, whom to eat with, how leisurely to eat. True choice, not token choice. Not the win-lose choice between a hot breakfast and sleeping to the rhythm of your day. Not simply the choice of hot or cold cereal, but also the raisins and brown sugar that make oatmeal a daily pleasure.”



“I’m a firm believer in the rights of elders to do whatever the hell they want. If you only have the right to make the ‘good, wise’ decisions that your grown daughter agrees with, then you’re not running your own life anymore. I’ve taken care of lots of people who didn’t even know their own children. Sure, they probably shouldn’t be making decisions about their 401(k) plans, but they can decide what to wear and what to eat and whether to go outside on a daily basis. People think that if old people cannot make the big decisions, they cannot make any decisions—and that is just wrong. They have the right to folly.”

Dr. William Thomas as reported by Brown, Nell Porter. “At Home with Old Age Reimagining Nursing Homes”
Harvard Magazine November – December 2008 The Alumni, <http://harvardmagazine.com/2008/11/at-home-withhold-age.html>. Accessed 10/15/09.



Shifting Traditional Professional Control to Support Self Directed Living

AMDA:

- “Person-directed care promotes resident choice and self-determination in ways that are meaningful to the resident.”
- Key component in geriatric medicine for decades
- Medical Directors and professional staff should work with the facility to “provide person-directed care while maintaining clinical excellence.”

ADA:

- “Research has not demonstrated benefits of restricting sodium, cholesterol, fat and/ or carbohydrate in older adults.”

CMS:

- Residents have the right to refuse treatment, CMS Tag F151
- Residents have the right to informed choice, CMS Tag F325
- Residents have the right to choice, CMS Tag F242



Related Research Trends and Current Thinking

- The homemaker or cook in the household gets to know what the residents want to eat, most of our residents have been experts in preparing meals.
- The kitchen created a setting where life is normal, livelier and residents in turn eat better, sleep better and need less medicine.
- Everyone needs to know that we will do what is clinically best for our residents, but if they refuse, that's okay.
- “Self-directed living includes honoring the resident's choice even in the face of family disagreement. POA does not give the right to demand restricted diets or altered consistencies.”
- “While alcohol is not a medical treatment, it may present certain risks. It is for some elders, a lifestyle choice.” Consult the Physician.
- All decisions default to the person.

New Negative Outcomes

- **AMDA:**
 - “Geriatrics is a discipline that emphasizes medical care in the proper context, including its impact on function, quality of life and personal preferences.”
- **ADA:**
 - “For many older adults residing in health care communities, the benefits of less-restrictive diets outweigh the risks. When considering a therapeutic diet prescription, a health care practitioner should ask: Is a restrictive therapeutic diet necessary? Will it offer enough benefits to justify its use?”
- **CMS:**
 - Tag F325 Nutrition, Deficiency Categorization

Severity Level 4 - Immediate Jeopardy:
Substantial and ongoing decline in food intake resulting in significant unplanned weight loss due to dietary restrictions or downgraded diet textures (e.g., mechanic soft, pureed) provided by the facility against the resident’s expressed preferences.

Severity Level 3 - Actual Harm:
Unplanned weight change and declining food and/or fluid intake due to the facility’s failure to assess the relative benefits and risks of restricting or downgrading diet and food consistency or to obtain or accommodate resident preferences in accepting related risks.



Current Thinking

“ Professional standards direct nurses to act to *prevent unsafe, illegal, and unethical practices* and protect patients who may be at risk. Nurses are educated to look for errors in medication and treatment orders, and to look for adverse outcomes related to medication and treatments. When a resident refuses a medication or treatment, the physician is promptly notified. Sometimes this standard does not translate into other aspects of care, such as acting on evidence that nutrition practices are not achieving intended outcomes. When a resident refuses a meal food or is observed consuming minimal amounts of food, prompt action is needed. Using current practice standards, physician notification may not occur until the resident loses weight. A proactive approach, which employs the nursing process, for all aspects of care, including nutrition, should be the practice standard. The nursing process, which involves assessment, diagnosis of need, planning of resident’s care, implementation, and evaluation of success of implemented care, supports honoring resident preferences and implementing dining practices that support choice.”

“The Reasonable Person Concept is defined as when a resident’s reaction to a deficient practice is markedly incongruent with the level of reaction the reasonable person would have to the deficient practice (CMS). Even if a resident’s reaction is that it is “fine” for her/his choice not to be honored this is “markedly incongruent” with a reasonable person like you and I living in the community at large. If someone gave us decaf coffee when we wanted caffeinated or woke us up according to when they thought we should get up, we would not be happy about it ... to say the least. I ask people all over the country how many of them do not even eat breakfast. Inevitably half the crowd raises their hands whether there are 8 or 800. Half of us do not eat breakfast. What is the number one driving force in every nursing home every day for getting people up? Breakfast. Why do we even wake people up at all? Breakfast. I ask my half a crowd how they would feel about being awakened from sleep to eat a meal they didn’t want. They say “mad” and “angry.” Someone inevitably says they would be “non-compliant” and administered a psychotropic drug in order to be compliant. Unfortunately, this is the norm, according to my audiences. This is Unnecessary Drugs. This is restraining a person for the convenience of staff, for honoring what a CNA once called the “almighty schedule” not the person. This is noncompliance with the federal requirements. It is the dawning of a new day to realize there are negative outcomes we are not considering and people’s health and well-being are in the balance.”



Shopping List- Mom- age 85

- 3 bags of Butterfinger pieces
- 1 bag dove mint chocolate
- 2 8- packs of Pepsi
- 1- pack of PF Chessman cookies
- 1- 12 pack Vanilla Activia and 1 4-pk
- 2-macintosh apples
- Peanut butter
- 4 monster muffins- no fruit flavors
- Canned soup- beef vegetable and clam chowder
- Cran-Grape Juice
- Gravy
- Flowers and Lottery ticket
- **Is there any reason to think that this list isn't self directed!**



Does she eat any real food? Yes!

- She also gets several dinners made up at a local market and also gets their homemade baked oatmeal.
- She divides the dinners into portion sizes that would not satisfy an infant and freezes them to be reheated.
- Her serving size is honestly no more than 3 tablespoons at a time.



What would happen if she came to your Nursing Center

- You'd need to serve her the smallest portion possible.
- She eats lots of small snacks, all through the day and evening
- She would only eat what she wants and refuse if she didn't like the item or the portion was too big and...
- She would probably not come to the dining room.



Who will we be serving?

- Folks worried about their nutrition.
- People who are used to sending food back when they aren't happy with it.
- “ Can you make that without peppers?”
- People who aren't worried about their diet or nutrition!
- People who are very used to a wide array of ethnic foods
- People who are used to ‘eating out’
- Snackers
- People who know how to complain



What does dining need to look like as we move forward!

- Choices
- Pepsi and Coke
- No more applesauce and chocolate pudding
- Chobani or Activia
- Beer or Wine
- Cheeseburgers and Fries, Pizza, Chinese
- Sorry, I don't want to eat a meal, just do some snackies
- ... are we going to be able to adjust!



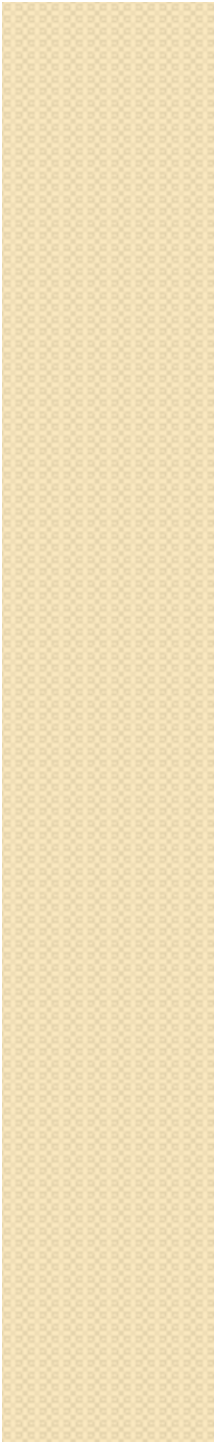
Garden Spot Journey

- Opened our skilled nursing households in 2007.
- Country kitchens in all households
- The sounds and smells of the kitchen
- Breakfast at will
- Focus on fresh food
- Choice in everything we do
- Extensive alternate menus
- Special events
- Household determine how their dining room is set up
- Residents decorating table for holidays



How does it feel to walk into our dining areas?

- Warm and inviting
- Smells great
- Residents sitting at the counter in the afternoon with drinks and snacks, visiting with the homemaker as she readies for supper.
- Small clusters of residents eating together
- Someone eating in the Living room and a TV table, someone else eating at the bar.
- Staff assisting residents, reading the newspaper with them.
- Volunteer engaged with staff and residents
- It doesn't feel rushed, isn't noisy or overcrowded.



Tablecloths in one Household, none in another.
Centerpieces and holiday decorations
Perhaps music playing softly in the background
The sounds of the kitchen, silverware clanging, plates touching
Windows to watch the weather
Visitors, Spouses and staff eating with residents
Staff assisting residents with menus, explaining the selections
Fresh fruit on the counter
Pastries under a cake server
China that the residents have chosen
Glass tumblers
Flowers
Hydration Station
Refrigerator Rights
Cloth napkins
Holiday table settings
Decorating the households seasonally



Quick thoughts on Household Kitchen safety:

Preparing and serving food in the household:

...Food Safety always comes first!

- Proper hand hygiene, before and after resident contact, eating or handling food, assisting residents with feeding. We use the concept "Clean girl, Dirty girl" The staff member who is designated as the 'clean girl, would be pouring drinks, serving the salads and entrées, with special care not to touch residents, dirty dishes etc. The 'dirty girl' removes the dirty dishes, adjust residents clothes etc.
- Proper glove usage
- Aprons
- Hand washing and reapplying gloves as needed.



Creating home

- Daily Pleasures- as I'm sitting in my office completing this presentation. This is what I am hearing,
- “I just started a fresh pot of coffee.”
- “We have a blueberry crisp this morning, would you like to try it?”
- I asked Eleanor how her Pizza was last night, she said “great, but I could only eat half. I say, “did you put the rest in the refrigerator?” “no, it's in my room”... Oh well, haven't we all eaten cold pizza like that the next morning!