Iowa Dietetics in Health Care Communities

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In This Issue:

From the Chair…

By Stephanie Labenz, MS, RD, LD
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Hello fellow IDHCC members,

I hope this finds you all well and had some time to enjoy the holiday season. With these past few years being crazy, any down time we can spend with our families is a blessing.

The board and council continue to meet almost monthly with ongoing discussion regarding our future as a group. Looking at this new year ahead, we really need members to step into volunteer roles to keep this group vital. Consultant dietitians are such special people. You are self-motivated, responsible, personable, knowledgeable, and team players (I couldn't think of another "able" word 😊). Being a consultant can mean so many things. Please consider volunteering as part of your New Year's goals.

I hope you have been receiving the pertinent and timely information from Kathleen Niedert. Kristen Simon-Frank has been emailing the documents as she receives them. Great information on CMS updates! Please let us know if you are not on the email list. Since stepping away from LTC, I rely on my fellow RD's to keep me up to date with current trends. What I am hearing is infection control continues to be a favorite for surveyors. Please make sure your auditing tools are current for the kitchen and dining rooms.

Let us know what you would like to see in the newsletter. We are calling on anyone with a topic or idea to share with us for our next issue. We would love to start highlighting RD's to see what is going on across Iowa. If you or you have a friend that would like to be showcased, please let us know.

Save the date: April 8, 2022, will be the next **LIVE** IDHCC meeting. Andrea Maher has been working nonstop to plan a fun, interactive, and very educational event for us all. We are going to dive deep into the physical nutritional assessment. Looking forward to seeing you there! More information to come, so stay tuned.

Thank you to the board and council for volunteering their time and energy to IDHCC and thank you to the members for supporting IDHCC. Can't wait to see what 2022 brings.

Cheers,
Stephanie

To Supplement or Not to Supplement:

Determine if they meeting their nutritional needs.

Why are you using a nutritional supplement

To Supplement or Not to Supplement

By Becca Van Roekel, RD, LD
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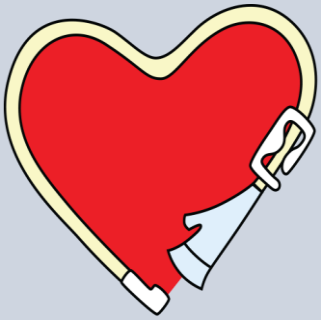
As a dietitian we are seen as experts within the nutrition field on a variety of topics. One that seems to come up is the topic of supplementation. Before considering the addition of supplementation it is crucial to look at the individuals past, present, and future nutritional goals as well as their nutritional habits. Often this involves asking key questions such as how many meals they typically eat in a day, examples of food items consumed in a day, recent weight changes, appetite, acute/chronic illnesses, etc.

This can give a sense of how if they are meeting their current estimated energy needs. Additionally, this can determine nutritional goals that may be set forth for the individual. Some individuals are content with their weight and shy away from the addition of supplementation.

I have found that some of the concern stems from being afraid they will be too full on the supplement to consume their meal or fear that they may gain weight. With the long-term care population the biggest thing looked at is meal consumption, weight trends, and goals for the individual. Often a big question asked in the field is the different types of supplementations that are available and utilized. With the current food industry luckily, there are plentiful options with a variety of flavors, volume options, and even tailored to different disease states such as kidney and diabetes. Many of the current options available in the stores are the typical Ensure, Boost, etc. however, in the healthcare setting we have a wider variety of options available.

One supplementation I have found being used more are the 2.0 supplements that can provide the same nutritional value with calories and protein with a fraction of the volume. This can be a big selling point to those who do not have as much of an appetite. Another big selling point when it comes to considering supplementation in individuals is having the addition of calories and protein when meal intakes are not adequately meeting needs. The addition of supplementation can assist with weight gain or weight maintenance which in turn can assist with maintaining if not improving mobility and in turn muscle mass.

When it comes to considering the addition of supplementation it is important to note this can either be a plan A or plan B for an individual. Individuals can in a way perk up with the addition of nutritional foods to provide additional calories and protein with adding butter to vegetables, whole milk with meals, cottage cheese, ice cream, etc. However, some of the nutritional interventions may not be enough and may not work if people are not eating their meals to benefit from the nutritional extras, which in turn is where the addition of supplementation can benefit.



Tube Feeding Myths - Part 1

Common myths behind explained.

Tube Feeding Myths—Part 1

Adapted from a FNCE 2021 Session

By Kathleen Niedert, PhD, RD, CSG, LD
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Many of you may have attended virtual FNCE 2021 but for those that didn't I wanted to review information that was presented on the myths often associated with enteral feeding. Much of the material presented here is adapted from the session, Dispelling Myths in Enteral Nutrition: Enteral Access. All three presenters did an excellent job discussing traditions that have been propagated for as long as I can remember with little evidence. As one of the presented stated, "Myths don't require evidence." Myths often hinder the resident's care as they produce inefficient and low-quality care. They are not good for our residents and can even be dangerous practices.

One can ask— "Why does this happen when the dietitian is taking orders from the physician?" It happens because physicians and primary care providers are expecting the dietitian to lead the way. Physicians, as we all know, have limited medical school education in nutrition. There are several reasons for this starting with lack of instructors, lack of time within their curriculum, and unfortunately, nutrition education is not a high priority. It is our job as dietitians to debunk the myths and educate the physicians on the appropriate care that needs to be provided to those on enteral feeding. This is our time to take the lead in providing quality nutrition care.

There was great discussion on the importance of nursing and the dietitian collaborating to improve enteral nutrition administration practices. Nursing can often begin the screening process to aid the RDN in the initial assessment. The RDN should also be rounding and consulting routinely obtaining information from nursing on consumption, intolerances identified, reinforcing education and the nutrition plan with the resident and the family. It is a true team approach with physician, nursing, and nutrition services.

So, let's get to the meat of the myths discussed. I am going to review the 15 myths discussed during the presentation. This will touch the high points of this session, but I hope that you will consider attending FNCE 2022 in Orlando to obtain cutting edge education in our first face-to-face conference in two years.

Myth 1. NG Decompression tubes can be used for prolonged EN Administration. NGs are NOT comfortable. They should be used for suctioning and lavage but not for enteral feeding. They are large bore (12-18 Fr), are more rigid and can cause sinusitis and pressure related skin breakdown. They should not be used for prolonged EN administration.

Myth 2. Low-profile or "button" EN Access devices are only for the pediatric population. The truth is, low-profile or button tubes can be used in adults. They may not be used as often in the nursing home population except for those with declining mental status but in those adults residing in community situations, they help them maintain an active lifestyle, are easy to hide and are less likely to be accidently pulled out—the reason they might be considered for those with dementia.

Myth 3. Patients/residents should not be fed for 24 hours following PEG placement. There are studies in the 1990s that demonstrate early feeding has no detrimental effect on the resident. Most current research suggests that

there are no signs of complications when feeding is initiated within 4 hours of placement.

Myth 4. Peri-tubular leakage around gastrostomy or jejunostomy tube sites can be fixed by placing a larger diameter tube. If you remember your physics, then you realize that placement of a larger tube only makes the hole larger. Placing a larger gastrostomy or jejunostomy tube is exactly what you DO NOT want to do. Identifying the problem and fixing it is.

Myth 5. Jejunostomy tubes are associated with frequent complications. J-tubes are smaller in caliber. Complications are no different than any other enteral feeding access. There will always be placement challenges, clogging, need for proper positioning, and feeding intolerance. As the speakers stated, with good placement, adequate and frequent flushing and proper medication administration, complication can be minimized.

Myth 6. NG tubes can be verified by auscultation or visualization of gastric fluid. This is absolutely false. There is no way to differentiate between gastric and pulmonary placement except with the use of radiography---the "gold standard." This is especially true with those who are critically ill, the elderly, and dysphasic or unconscious patients. Auscultation may not differentiate between respiratory and gastrointestinal placement of the NG tube. Sounds may be transmitted to the epigastrium whether the tube is positioned in the lung, esophagus, stomach, duodenum, or proximal jejunum. The speaker also stated that examining aspirate and measuring the pH may be inconclusive related to H2 suppressant medications often used in enteral nutrition that change the pH of aspirate. Utilizing the color of the gastric residual is also not effective as a method because the color can be deceiving. More than 1.2 million small-bore feeding tubes (SBFT) are placed each year in the U.S. Of these 1.2-2% SBFT blindly placed enter the airway undetected with 0.3%-0.7% causing pulmonary injury. Of these, 0.1%-0.3% patients with pulmonary injury will die. These seem like small percentages, but the real numbers are somewhere between 3600-8400 pulmonary injuries that result in 1,200-3,600 deaths.

Supply Chain Challenges Resulting in Menu Substitutions:

Have a substitution policy

Document substitutions

Communicate

Supply Chain Challenges Resulting in Menu Substitutions

By Mary Sell, MPA, RDN, LD, Menu Services Manager with Martin Bros.
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Food product availability and staffing shortages have become more prevalent since the pandemic began making it difficult sometimes to serve the foods you've so carefully planned on your menus. Analysts predict these challenges will continue well into 2022.

What has contributed to the broken supply chain?

- The cost of raw materials has skyrocketed due to increase in demand and shortage of supply.
- The cost to ship containers overseas has increased by 500%
- Hundreds of ships are anchored at sea waiting to offboard
- Driver shortages are adding to the delay in getting product delivered to the suppliers, then to the distribution partners, then to you
- Labor shortages and plant reconfiguration to accommodate social distancing requirements have slowed production.

With these new challenges many of us find ourselves making menu substitutions more frequently than we had in the past. Consider these best practices when making menu substitutions in senior living communities.

- Have a **Substitution Policy** that states:
    - What situations allow for menu substitutions
    - Who is able to determine substitutions
    - Standard equivalents for each food group and key nutrients
    - How therapeutic diets are handled
- Document menu substitutions in a **Substitution Log** to be regularly reviewed by the dietitian that includes:
    - Date and meal of substitution
    - Item that was planned originally, and what was offered as the substitution
    - Reason substation was made
- **Communicate** with residents and their families
    - Display menu changes in an area that residents normally see the posted menu.
    - Discuss why changes are happening at resident council meeting and what you are doing to work with your vendors.
    - Convey information about supply chain challenges to families

Communication is the key to earning patience and good-will from your residents and their families. Keeping residents updated about the challenges and what you are doing to ease the situation will help keep dining satisfaction high.

Spring IDHCC Conference:

8 April 2022

Northcrest Community in Ames, IA

Save the Date – 8 April 2022

Spring IDHCC Conference: Let's Get Clinical

Next LIVE Meeting at Northcrest Community in Ames, IA

Topics Included:

Nutrition-Focused Physical Exam: training by ISU Professors

Oral Care

Individualization of the Renal Diet

Infection Control:

Forms Included to Use

Audits for Infection Control

From Andrea Maher, RD, LD

FS Staff Infection Control Audit for kitchen observations
FS Audit – Big 6 Pathogens for ensuring food service staff are aware of the responsibility to report illness and knowledge of sanitizer/disinfectants and contact times.
Unit Meal Dining Observation Audit for meal times.

Staff PPE/Infection Control Audit

Staff PPE/Infection Control Audit Unit/Area__________________ **Auditor:** ___________________________

Complete at least 6 observations each week.

Date	Staff Initials	Staff member is wearing gloves during the appropriate time/task? (If no, comment on the area & task)	Staff member washed their hands after returning from break.	Staff member keeps their mask on- covering nose and mouth. *If mask is touched, hand hygiene is done immediately afterwards*	During kitchen observation, all used rags in red/green buckets only (if no, please educate staff member(s) around).	Comments i.e. – corrected education done
		☐ Yes ☐ No ☐ Not Observed	☐ Yes ☐ No ☐ Not Observed	☐ Yes ☐ No ☐ Not Observed	☐ Yes ☐ No ☐ Not Observed	
		☐ Yes ☐ No ☐ Not Observed	☐ Yes ☐ No ☐ Not Observed	☐ Yes ☐ No ☐ Not Observed	☐ Yes ☐ No ☐ Not Observed	
		☐ Yes ☐ No ☐ Not Observed	☐ Yes ☐ No ☐ Not Observed	☐ Yes ☐ No ☐ Not Observed	☐ Yes ☐ No ☐ Not Observed	
		☐ Yes ☐ No ☐ Not Observed	☐ Yes ☐ No ☐ Not Observed	☐ Yes ☐ No ☐ Not Observed	☐ Yes ☐ No ☐ Not Observed	
		☐ Yes ☐ No ☐ Not Observed	☐ Yes ☐ No ☐ Not Observed	☐ Yes ☐ No ☐ Not Observed	☐ Yes ☐ No ☐ Not Observed	
		☐ Yes ☐ No ☐ Not Observed	☐ Yes ☐ No ☐ Not Observed	☐ Yes ☐ No ☐ Not Observed	☐ Yes ☐ No ☐ Not Observed	

Comments:

Supervisor Infection Control Audit/Big 6 Pathogens

Supervisor Infection Control Audit/Big 6 Pathogens Ask employees all of the following questions.

Date	Staff Initials	Can you tell me what ill symptoms would exclude an employee from working around food? *	Can you tell me how long you must wait before returning to work after your last symptom of illness? Answer: **24 hours**	Can you name the Big 6 Foodborne pathogens? ** *(Employee can refer to where this is posted)*	Infection Control QU: Can you tell me what the <u>contact time</u> is for the sanitizer? Answer: **1 minute** *(note: this answer can vary depending on the sanitizer used at facility)*	Infection Control QU: Can you explain what is meant by "contact time" for sanitizer and disinfectant products? ***	Was education provided to this employee?
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No ☐ NA
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No ☐ NA
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No ☐ NA
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No ☐ NA
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No ☐ NA
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No ☐ NA
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No ☐ NA

*sore throat with fever, vomiting, diarrhea, jaundice *(make sure they know where the algorithm is located in food service/make sure they have a badge)*

** <u>**Big 6 Foodborne pathogens**</u>: Shigella, E. Coli, Nontyphoidal Salmonella, Salmonella Typhi, Hepatitis A, Norovirus

*****Contact (Dwell) Time**: The amount of time that a sanitizer or disinfectant must be in contact with the surface, *and remain wet*, in order to achieve the product's advertised kill rate. Do not reuse the item until the contact time is complete.

Auditor/Educator: ______________________________ Unit/Household: _________

UNIT MEAL DINING OBSERVATION

Instructions: **Observe five hand hygiene opportunities per week/month.** Record findings with a check mark below.
Note: Hand hygiene refers to use of waterless hand sanitizer or washing hands with soap and water for at least 20 seconds.

MONTH OF OBSERVATION:_____ COMPLETED BY:_____

MEAL OF OBSERVATION (Bk, L, S)										
AREA OF OBSERVATION										
INITIALS/STAFF TITLE OBSERVED										
Note: Only check boxes if an observation is made, otherwise leave blank	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Hand hygiene prior to passing meal trays										
Hand hygiene before & after glove use										
Hand hygiene in between carrying trays <u>if resident contact made</u>										
Handling ready to eat foods with a barrier, not bare hands										
Handling cups/glasses on the outside of the container										
Handling knives, forks and spoons by their handles										
Preventing the eating surfaces of plates touching staff clothing										
Gloves are used appropriately for single task purposes										
Resident hand hygiene provided prior to meal										
Resident fingernails are observed to be clean										

Titles: RN, LPN, CMA, CNA, PT- Physical Therapy; RD- Dietitian; SW- Social Worker; RT- Recreation, Other (identify department)

Use the space below to record any educational opportunities afforded.

Staff #1 _____

Staff #2 _____

Staff #3 _____

Staff #4 _____

Staff #5 _____

IDHCC Zoom Board Meeting

16 December 2021

Present: Stephanie Labenz, Kristen Simon-Frank, Andrea Maher, Julie Halfpop,

Future of IDHCC discussed: Stephanie reported on her visit with Ruth Litchfield about being an internal vs external practice group.

If we went internal: Our money would stay with our group, it would not be turned over to IAND. We would still need a treasurer. We might need to present a budget, which is a good idea anyway. Bylaws can be changed as needed. Stephanie and Josh could set up a PayPal account for membership and it would all go through IAND. Current job descriptions would need to be updated; or might utilize committees or teams, such as marketing or lunch and learn. May consider discontinuing our separate newsletter and submit content to IAND newsletter.

Value for IDHCC Membership-
Continue to keep membership dues low
Newsletter Makeover- highlight an RDN
Foodservice section
Auditing tools/Resources
Articles
Meeting minutes, comments from the chair, upcoming events
Link to IAND newsletter and IAND website
Email? Or snail mail?

Will ask Ruth L. if we can get email list for all IAND members and send everyone a free copy of our January newsletter to raise awareness of our group. January Newsletter to include Infection Control audits from Andrea and Kathleen N.'s article on 15 Myths of Enteral Feeding Note that there are about 1200 RDs in Iowa who are not IAND members. IAND is considering paying members who bring in revenue to the group as an incentive to get leaders.

Connect with facilities in IA; Is your RDN a member?
Connect with RD business groups: Are your RDN employees members?
Lunch and Learn- included in dues. Topics include hospice, enteral feeding, wounds, litigation…
Spring Conference- CEUs and networking

Nominations- a challenge at all levels from regional to national. Try to match member's interest to the task.
Open positions: treasurer, chair elect, nominations junior

Spring Conference update- Andrea has made great progress planning this event.
Site selected- Northcrest in Ames- for a very reasonable fee!
Speaker fees will also be affordable
Parking- limited- may need a shuttle system
Food will be brought in. Julie will work with General Mills for breakfast. Can get box lunches.
Attendance Fee- $50? $75? No firm decision yet
Lodging- attendees will make their own arrangements. Publicity brochure will include names of nearby hotels.
Vendors- site does not have a separate room for vendors. Still working out logistics for this.
Perhaps a get-together for board members the night before.
Andrea can start working with Josh on registration.
Program- Hands-On Nutrition Focused Physical exam- 2 hours presented by Iowa State

Oral Health – 2 hours Mary Kelly
Business Meeting and Lunch
Modified Renal Diet- 1 hour DaVita Renal RD Lindsey _____
To Be Determined- 1 hour
Conclude at 4 pm

Next Zoom call will be Thursday, January 20th at 7 p.m.

Minutes submitted by Kristen Simon-Frank, RDN,LD

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