POLICY: Physical Nutritional Management

PURPOSE: The purpose of the policy is to provide guidelines for developing physical nutritional management plans and to outline the responsibilities of physical nutritional management teams.

APPROVED BY: Joe Vesowate  
Assistant Commissioner  
State Supported Living Centers

APPLIES TO: All employees, agents, and contractors of State Supported Living Centers operated by Texas Department of Aging and Disability Services (DADS) and the ICF-IID component of Rio Grande State Center operated by the Department of State Health Services, collectively referred to as “State Centers.”

DISTRIBUTION: The State Center must ensure the policy, all exhibits, and forms are distributed to applicable staff, contractors, agents, and to any individual requesting a copy.

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EXHIBITS: N/A

REFERENCES:  
- Policy 004.1, Individual Support Plan Process (Integrated Protections, Services, Treatments, and Supports),  
- Policy 006.3, At Risk Individuals  
- Settlement Agreement, Section O  
- Health Care Guidelines, VI and VIII: Physical Management/Nutritional Management
**Definitions**

**Aspiration Pneumonia/Enteral Nutrition Data Sheet (APEN):** A data collection tool that must be completed at least annually if the individual: 1) has had aspiration pneumonia during the past year; and/or 2) receives enteral nutrition or medication. The APEN form requires input from many disciplines. The Interdisciplinary Team (IDT) uses the APEN data to promote an integrated discussion regarding the individual’s condition and to determine the best course of intervention. For individuals who receive enteral nutrition, the IDT should use an APEN to complete an annual analysis of the individual’s potential for return to oral eating and, as appropriate, identify the medical necessity of continuing enteral nutrition.

**Assistive Equipment (AE):** Any device provided to a resident to augment or substitute for function or to provide physical support, comfort, or therapeutic benefit and increase independence. Examples of AE include wheelchairs, mobility devices, gait belts, positioning devices, eyeglasses, arch supports, leg braces, hand splints, hearing aids, custom eating utensils, communication devices, and others.

**Change of Status (CoS):** Term used to identify that an individual has experienced a change in health, events, or behavior that prompts the need for an IDT review of services, supports, and existing risk rating.

**Clinical Indicators:** Measures to assess particular health structures, processes, and outcomes. Clinical indicators can provide a quantitative basis for quality improvement by identifying incidents of care that trigger further investigation; be used to assess aspects of the structure, process, or outcome of health care; or serve as generic measures relevant for most residents or for specific diseases to express the quality of care for residents with specific diagnoses.

**Competency-Based Training:** The provision of knowledge and skills sufficient to enable the trained person to meet specified standards of performance as validated through that person’s demonstration that he or she can use such knowledge or skills effectively in the circumstances for which they are required. (Settlement Agreement, p. 5)

**DADS:** Department of Aging and Disability Services. (40 TAC §3.101(13))

**Dining Plan:** A collection of instructions and pictures that describes precautions, equipment, diet texture, liquid texture, and triggers to alert staff to possible problems and to prescribe safe eating techniques for residents served.

**Facilitation Techniques:** Methods or techniques that can reduce abnormal reflexes, facilitate or inhibit muscle tone, or facilitate safe handling when touching, moving, or otherwise interacting physically with a resident.

**Individual or Resident:** A person with a developmental disability receiving services from a facility. (40 TAC §3.101(27))

**Individual Support Plan (ISP):** An integrated, coherent plan that reflects an individual’s preferences, strengths, needs, and personal vision, as well as the protections, supports, and
services the individual will receive to accomplish identified goals and objectives. The resident’s IDT develops the ISP following extensive assessments of the resident. 40 TAC §3.101(28)

**Integrated Health Care Plan (IHCP):** A plan developed by the IDT after risks have been discussed and analyzed during the Individual Support Plan (ISP) meeting. The IHCP includes such components as goals, action steps, services and supports, implementation date, persons responsible for implementation, documentation, data to be collected, the documentation tool, frequency of data collection, person responsible for the plan, person(s) responsible for efficacy of the plan, etc. The IHCP is completed on an annual basis. A Change of Status (CoS) IHCP is completed if an individual experiences a CoS that prompts an IDT meeting.

**Integrated Progress Note (IPN):** An on-going, centralized clinical record in which the provision and efficacy of related services, supports, and interventions provided for the resident are documented by the responsible disciplines and designated personnel. The IPN functions to provide a vehicle to consolidate information on the resident's progress and promote interdisciplinary decision-making based on such documentation.

**Interdisciplinary Team (IDT):** An interdisciplinary team with the active participation of the individual and legally authorized representative (LAR), that is responsible for assessing the individual's treatment, training, and habilitation needs and making recommendations for services based on the personal goals and preferences of the individual using a person-directed planning process, including recommendations on whether the individual is best served in a facility or in a community setting. (40 TAC §3.101(29))

**Legally authorized representative (LAR):** A person authorized by law to act on behalf of an individual, including a parent, guardian, or managing conservator of a minor individual, or a guardian of an adult individual. (40 TAC §3.101(30))

**Physical Nutritional Management Plan (PNMP):** A set of techniques and instructions developed to facilitate safe eating, medication administration, oral care, and lifting and transferring. The PNMP also provides instruction about proper positioning, use of assistive equipment and communication strategies. The activities in the PNMP are designed to prevent aspiration and respiratory difficulties and complications from enteral nutrition, to address gastrointestinal concerns and other high-risk medical conditions, reduce abnormal reflex activity, prevent/reverse joint contractures, facilitate normal muscle tone and movement patterns, facilitate skill acquisition, and promote and maintain comfort and good health. The plan is designed to span a 24-hour day, seven days per week, and is developed to meet the needs of a specific resident.

**Physical Nutritional Management Team (PNMT):** A team of specialists with knowledge and expertise in the development of PNMPs who provide comprehensive assessment and determine appropriate intervention for persons at high risk of potential or actual injury and/or illness who are not stable and for whom the team needs assistance developing a plan.

**PNMT Evaluation:** A summary of the findings of the PNMT including assessment results, analysis of clinical findings, recommendations and rationale, measurable objectives,
recommendations for revisions to the ISP, action plans, persons responsible for actions, criteria for review/reassessment, and timelines for monitoring and reporting.

**Positioning:** The use of specialized postures designed for residents to promote comfort, enhance function, or to achieve a therapeutic end.

**Primary Care Provider (PCP):** A physician, advanced practice nurse, or physician assistant who provides primary care to a defined population of patients. The PCP is involved in health promotion, disease prevention, health maintenance, and diagnosis and treatment of acute and chronic illnesses.

**Qualified Developmental Disability Professional (QDDP):** A state center facility employee responsible for integrating, coordinating, and monitoring an individual's ISP who meets the requirements of 42 CFR §483.430.

**Registered Nurse:** A nurse licensed by the Texas Board of Nursing to practice professional nursing in Texas. (40 TAC §3.101(41))

**Transferring:** The movement of residents physically from one place to another by mechanical lift, manual lift, standing transfer, or other approved methods.

### I. State Center Responsibilities

All State Centers must implement this policy consistently and effectively by:

A. Establishing and maintaining a designated **Physical Nutritional Management Team** (PNMT) with a dedicated registered nurse that evaluates and analyzes assessment information and provides recommendations for residents at high risk for whom the team requires assistance;

B. Providing **Physical Nutritional Management Plans** (PNMPs), mealtime positioning/dining plans, medical interventions, and other specialized services to residents who have been identified with such needs;

C. Ensuring that staff engage in mealtime, medication administration, and oral care practices that do not pose undue risk of harm to residents;

D. Ensuring that residents are in proper alignment during and after eating and during enteral feeding, medication administration, oral care, and other activities that may provoke swallowing difficulties;

E. Ensuring that residents who eat by tube are evaluated to determine whether a tube is medically necessary and plans are made to return to the least restrictive method of eating as appropriate;
F. Developing physical and nutritional management services through the Interdisciplinary Team (IDT) and ensuring that PNMPs are integrated into the Individual Support Plan (ISP);

G. Requiring that PNMPs are carried out as instructed through inclusion into IDT activities and assignment of responsibility to specified IDT members;

H. Monitoring and updating plans in response to changes in residents’ needs through changes in risk level and presence of clinical indicators;

I. Providing competency-based training to staff initially and retraining staff as changes occur; and

J. Ensuring that the IDT is apprised of changes in the PNMP and such changes are integrated into the ISP.

II. The Physical Nutritional Management Plan (PNMP)

   A. All residents who require physical nutritional management services will be furnished with a PNMP or mealtime and positioning/dining plan. All residents who cannot feed themselves are at risk for choking or aspiration, and who require positioning associated with swallowing will be identified and provided with plans and supports sufficient to meet their needs.

   B. The PNMP is written to meet identified needs and is based on input from the PNMT, habilitation therapies, medical and nursing staff, the IDT, home staff, and others as appropriate. It must be written in a clear, concise manner that is easily understood by staff carrying out the plan. The PNMP should be discussed and approved by the IDT, integrated into the ISP, and be readily available for staff reference.

   C. Assistive equipment should be appropriate for the prescribed use, effective, well fitting, well maintained, clean, and aesthetically pleasing.

   D. The PNMP must minimally include the following elements:

      1. Risk areas and triggers for risk areas addressed in the PNMP;

      2. Specific positioning regimes as needed, including positioning for oral and enteral eating, oral care, medication administration, prevention of aspiration pneumonia and complications of Gastro Esophageal Reflux Disease (GERD);

      3. Appropriate diet texture and liquid viscosity, dining techniques and strategies to facilitate intake and promote safe eating practices;

      4. Instructions for medication administration, mealtime practices, and oral care;
5. Assistive equipment used in implementation of the program, its purpose and its schedule for use;

6. Lifting/transfer, mobility, and movement techniques;

7. Communication strategies;

8. Any precautions to be observed because of underlying medical conditions or risks; and

9. Any other special services required to meet identified PNMP needs.

**III. Implementation of the PNMP**

A. The PNMP is addressed at the annual planning meeting and as often as needed.

B. It is approved by the IDT and included as part of the ISP.

C. The PNMP is to be implemented in all areas including hospitalizations, outings, social events, and other environments.

**IV. The Physical Nutritional Management Team (PNMT)**

Residents identified by the IDT who are at high risk as defined by the facility policy and for whom the IDT has been unable to achieve a satisfactory outcome or remediate the risk level may be referred to PNMT by the Primary Care Physician (PCP), PNMT, or IDT for assessment and recommendations for interventions and supports.

A. **The purposes of the PNMT are to:**

1. Perform comprehensive assessment of specific risk and related areas for residents identified as being at high risk and for whom the IDT requires specialized services;

2. Develop Integrated Health Care Plans (IHCP) for individuals served by the PNMT in conjunction with the IDT. The IHCP plans should include risk factors, rationale for risk, subjective and objective findings, criteria for immediate referral to PCP, action steps, measurable goals, implementation date, person responsible for implementation, monitoring frequency, person responsible for review of progress and efficacy, and completion date;

3. Identify resources needed to implement the plan; perform interventions identified in the plan; and identify monitors, monitoring schedules, criteria for discharge and reassessments determined by risk level and outcomes;

4. Collaborate and integrate actions with the IDT;
5. Monitor and reassess the resident’s health status until established outcomes are met;

6. Document progress in the Integrative Progress Notes (IPN);

7. Reassign responsibility to the IDT with recommendations for treatment and supports and level of monitoring as appropriate;

8. Train staff as indicated in action plan;

9. Observe and assess the resident in a variety of settings to ensure the objectives are appropriate to effect positive change or to determine further PNMT involvement; and

10. Maintain communication with the IDT to ensure continued progress.

B. PNMT Referral Criteria (Minimum):

1. Two choking episodes in one year;

2. Two Aspiration Pneumonias in one year;

3. Results of PNMT Nurse post-hospitalization assessment:
   a. Aspiration Pneumonia;
   b. GI Issues;
   c. Fractures;
   d. Skin Integrity; and
   e. Seizures;

4. New or proposed enteral feeding;

5. Unresolved vomiting (>3 episodes in 30 days not related to viral infection); or

   a. >5 lbs. in one month;
   b. 3 or more pounds or 7.5% consecutively for 3 months; or
   c. 10% of body weight in 6 months;

7. Any stage III or IV decubitus, and any stage II with delayed healing; or
8. Fracture of a long bone, spine, or hip.

C. Core members of the PNMT must have specialized training or experience working with residents with complex physical or nutritional problems. Core members must include:

1. A registered nurse (dedicated);
2. A physical therapist;
3. An occupational therapist;
4. A dietician; and
5. A speech pathologist with demonstrated competence in swallowing disorders.

D. Other participants, upon request of the PNMT, may include:

1. The medical doctor or primary care practitioner;
2. The case load therapist;
3. The nurse case manager;
4. The psychologist;
5. The QDDP;
6. Dental staff;
7. A pharmacist;
8. Facility support services staff; or
9. Others as needed.

E. General responsibilities of PNMT members include but are not limited to:

1. Providing required/assigned information for PNMT meetings, e.g., current assessments, test results, medical information, lab reports and other information as needed;
2. Actively participating in the PNMT meetings through synthesizing and analyzing assessment data;
3. Performing comprehensive assessments of identified risk and related areas;
4. Using critical thinking skills to identify causes and formulate effective strategies to reduce risk and improve health status;

5. Performing interventions and monitoring as assigned;

6. Training staff and monitors in expected responsibilities and outcomes;

7. Collaborating with the IDT throughout the process and integrating PNMT recommendations into the ISP; and

8. Performing other activities as appropriate.

F. Responsibilities of the PNMT Nurse include:

1. Attending daily medical meetings to keep abreast of resident’s health status;

2. Reviewing Nurse Post Hospitalization Assessment or performing additional assessment following hospitalization for aspiration pneumonia/respiratory issues, GI problems, skin issues, seizures, and falls/fractures to determine need for PNMT involvement;

3. Performing specialized assessments specific to identified risk areas;

4. Analyzing assessment results and development of recommendations with measurable goals;

5. Participating in development of the IHCP, for individuals followed by the PNMT;

6. Documenting in the IPN;

7. Performing treatment/oversight to residents served by the PNMT;

8. Monitoring implementation of PNMT recommendations by the IDT;

9. Periodically re-evaluating effectiveness/completion of recommendations; and

10. Collaborating with the Nurse Hospital Liaison for visitation of residents seen by the PNMT during hospitalization.

G. Responsibilities of PNMT Therapists/Dietician include:

1. Performing integrated assessments in collaboration with other PNMT members;

2. Performing specific assessments in clinical specialty areas;
3. Using critical thinking skills to analyze assessment data and develop appropriate action plans and treatment regimens;

4. Performing or providing therapeutic services to residents served by the PNMT;

5. Training staff in correct implementation of supports and documentation;

6. Ensuring implementation of action plans by the IDT; and

7. Periodically re-evaluating effectiveness/completion of recommendations.

H. PNMT meetings will be held at least weekly and as scheduled, but may also occur:

1. When a resident’s risk level or status changes;

2. When nutrition/health problems arise;

3. After Modified Barium Swallows or other medical diagnostic tests are performed;

4. Before final treatment decisions are made;

5. To perform follow-up activities; and

6. At any phase in the physical nutritional management process.

V. Monitoring of PNMP

PNMPs should be monitored as determined by need and risk level. Residents at high risk will be monitored at greater frequency to reduce the impact of high-risk conditions and to prevent recurrences if possible.

A. Monitoring may be performed by PNMT members, nurses, specialized therapy staff, other professional staff as assigned or scheduled, PNMP Coordinators, residential supervisors, and other IDT members.

B. Regular monitoring of programs, supports, and services is performed by the responsible IDT member at least monthly and more often as needed to assess the progress and efficacy of interventions.

C. Specialized monitoring of residents at high risk is performed by assigned staff and based on assessment results.

D. PNMPs should be monitored regularly by supervisors for continued implementation by direct contact professionals and to report any problems and training needs.
E. Equipment used in physical management programming (e.g., positioning and feeding equipment, wheelchairs, braces, splints, etc.) shall be monitored daily by direct contact staff for cleanliness, wear, and needed repair.

VI. Training

State Centers will complete staff training regarding PNM during new employee orientation and will re-train staff regularly in core elements and as changes in plans or procedures occur. All training will be competency-based and documented as stated in DADS/Facility policies.

A. Initial Training

1. Facility administration should receive training in policies, procedures, and fundamentals of physical and nutritional management to provide support for PNMT/PNMP activities.

2. Core members of the PNMT will successfully complete training in fundamentals of physical and nutritional management.

3. All direct contact staff, PNMP Coordinators, nurses, and other professionals responsible for implementing or monitoring PNMPs will successfully complete core/foundational training in physical nutritional management during new employee orientation using DADS-approved training. Training topics must minimally include:
   a. Risk guidelines;
   b. Aspiration pneumonia;
   c. PNMP philosophy, content, policies, and procedures;
   d. Techniques and equipment for residents served;
   e. Lifting and transfer;
   f. Positioning;
   g. Dining/eating/oral intake;
   h. Communication; and
   i. Monitoring procedures.

B. Ongoing Training

1. Staff will be trained as PNMPs and other pertinent programs and supports are developed, implemented, and revised and whenever a need for retraining is identified.
2. Staff assigned to high-risk individuals will be trained in individual-specific techniques or programs prior to working with high-risk individuals.

3. Staff will be determined to be competent through demonstration or verbalization, as appropriate. Documentation of training will include a competency check-off record and the signature of both parties to acknowledge that competency has been achieved.

4. Core/foundational training will be provided at least annually and as indicated by monitoring.

5. It is recommended that core team members direct part of their professional continuing education requirements in areas that relate to PNMT responsibilities.

6. Unit supervisory staff will minimize use of substitute direct contact professionals in the care of high-risk individuals or will ensure that such staff receive training on PNMPs of high-risk residents prior to working with those residents.

7. Monitors will be trained to assess assigned areas before being scheduled for monitoring duties.

VII. Data Collection

The State Center must have a quality improvement process for PNM teams as well as PNM plans that:

A. Collects and tracks activities of the PNMT and outcomes of individuals served;

B. Assesses data for trends;

C. Initiates outcome-related inquiries;

D. Identifies and initiates corrective action; and

E. Monitors to ensure that remedies are achieved.