

Providing a Quality Nutritional Experience for the Elderly in Long Term Care

A Feeding Assistant Training Program

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- American Health Care Association
- St. Elizabeth's Rehabilitation and Nursing Center
- HFAM Quality Improvement Committee Members
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- The staff of each HFAM member nursing facility that are committed to the welfare and quality of life of all residents served in our industry.

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How far you go in life depends on your being tender with the young, compassionate with the aged, sympathetic with the striving, and tolerant of the weak and strong. Someday in your life, you will have been all of these.

George Washington Carver

Preface

Purpose

Residents in Long Term Care facilities in the State of Maryland deserve quality nursing care, which includes assistance during meal times. Many residents do not need the skills of a Certified Nursing Aide but require assistance that can be provided by another trained individual.

This training program is designed to meet the federal requirements for feeding assistant training. It includes information about all of the topics required by the federal rule as well as other information that is useful and important for feeding assistants to have along with a practical exercise.

It is designed for any individual who will be feeding residents in a long term care facility. Volunteers and family members are permitted to feed residents without completing this training. However, it may be beneficial to them should they want to participate in it.

IMPORTANT:

1. Facilities may require feeding assistants to obtain CPR certification. All employees are required by Federal law to complete the facility's training on Blood-borne Pathogens. Facilities should use this minimum of 8 hour training as a baseline and may add other topics that they believe are appropriate to structure a feeding assistant program that meets their needs.
2. Facilities should maintain a record of individuals it uses as feeding assistants who have successfully completed the feeding assistant training. In keeping with other similar requirements, facilities should report to the OHCQ any incidents of feeding assistants who have been found to neglect or abuse a resident, or misappropriate a resident's property.
3. Feeding assistants are intended to supplement certified nurse aides, not be a substitute for certified or licensed nursing staff. Therefore, feeding assistants may not be counted toward the minimum staffing requirements in Sec. 483.30. Facilities that choose the option to use paid feeding assistants, when consistent with State law, remain responsible for any adverse actions resulting from the use of these assistants, as with any other employee.

Federal Requirements

Federal regulations are found in Title 42, CFR, Section 483.35(h) and course requirements are in Section 483.160. A copy of the final rule published in the Federal Register, September 26, 2003, is in appendix B

Definition of a Paid Feeding Assistant

A paid feeding assistant is an individual who is paid by a facility or paid under an arrangement with another agency or organization to feed residents and who meets the requirements specified in Federal regulations (Sec. 483.35(h)). Any nonprofessional nursing home employee, including the administrator, activity staff, clerical, laundry, or housekeeping staff may be considered a feeding assistant and may feed residents at mealtimes if he or she has completed the training requirements (Sec. 483.160).

Who may feeding assistants feed?

The facility may use paid feeding assistants to feed residents who do not have a clinical condition that would require the training of a nurse or nurse aide. It is important for the professional staff in the facility to identify residents who need help eating and drinking and those who can be fed by feeding assistants. This can be established by the comprehensive assessment. Often, residents need help on some days and not on others. This means that the nurse in charge may need to make feeding decisions on a daily basis. Nurses or certified geriatric nurse aides would continue to feed residents with clinical conditions that require nursing training, including for example, recurrent lung aspirations, difficulty swallowing, or those on feeding tubes or parenteral/IV feedings. All feeding assistants must work under the direct supervision of a registered nurse or licensed practical nurse. This means that a nurse is in the unit or on the floor where the feeding assistance is furnished and is immediately available to give help, if necessary.

Volunteers

These requirements do not apply to volunteers, including family members. Sections 1819(b)(5)(F) and 1919(b)(5)(F) of the Social Security Act exempt volunteers from the definition of "nurse aide" and nurse aide training requirements, which are more stringent than feeding requirements. Volunteers may take the training if they wish, but there is no requirement that they do so.

Topics Included in the Training

- o Proper feeding techniques and how to assist residents with eating and drinking,
- o Basic skills necessary to work with elderly and disabled nursing home residents such as:
- o Communication and interpersonal skills;
- o Appropriate responses to resident behavior;
- o Safety and emergency procedures, including the Heimlich maneuver; Infection control;
- o Resident rights;
- o Recognizing changes in residents that are inconsistent with their normal behavior, and
- o The importance of reporting those changes to the supervisor.



Some facilities may want to include other topics in their training, for example, the use of assistive devices. We are not, however, including these other topics. This training could easily be implemented in any facility with an approved nurse aide training program because the requirements are not new. This is also designed to stand alone for those facilities without a nurse aide training program. We note that these requirements are the minimum and facilities must use these as a baseline, but may add any others that they believe are appropriate to structure a feeding assistant program that meets their needs.

Facilities are encouraged to notify and provide to HFAM any changes, additions or deletions they view as necessary (and won't modify the CMS requirements except as additions). HFAM will update and revise the manual as needed.

Chapter 1

Changes in the Elderly

Chapter 1 Changes in the Elderly

Aging is a natural experience, not a pathologic one.

The elderly are our parents and grandparents who have raised their children and earned the respect, admiration, and dignity they deserve. They are at the point in life where they are beginning to experience losses in many areas: friends, loved ones, personal functions and abilities.

As we move toward the later stage of our lives, the changes that have been taking place become more evident. For example, the elderly person:

- ▶ May lose vitality,
- ▶ May sleep less at night,
- ▶ May benefit from rest periods during the day,
- ▶ Has tissue changes that effect the skeletal and smooth muscles.
- ▶ Has various parts of the body systems becoming less functional and with less nerve sensitivity.

The following is a brief discussion of changes we will all experience as we age and become part of the elderly population.

Bodily System Changes

Circulatory System - Throughout the adult years the heart muscle loses its efficiency and strength needed to contract efficiently. This decreasing ability to pump blood throughout the body affects all organs of the body over time. The brain may be affected by slowing down memory and the thinking process. It may cause a variety of other mental and emotional problems. Other issues may become evident like high blood pressure and a decrease in kidney function.

Respiratory System - The elasticity of the lungs decreases causing less lung capacity therefore less oxygen gets into the circulatory system. Muscles shrink throughout the body causing the rib cage to become more rigid making breathing more difficult.

Gastrointestinal Tract - Muscle tone decreases causing less motility and increased problems with constipation. Often teeth are lost and the glands producing saliva secrete less causing difficulty eating.

Central Nervous System – This system depends heavily on the circulatory system so changes are related to blood flow and the transfer of oxygen to the brain and various nerve cells. Movement of limbs and reflexes may decrease due to the circulatory decreases and muscle tone decreasing.

The Five Senses

Vision: decreases, especially in adjusting to light and darkness. There may be other vision issues like glaucoma and cataracts.

Hearing: decreases, between vision and hearing; these are the two ways we orient ourselves to time and our surroundings.

Touch: becomes less sensitive. The skin can become burned easily and less resistive to skin breakdown and sores.

Taste and Smell: both diminish greatly causing a variety of eating problems because they can't taste or smell the food.

Skeletal System— The bones of the skeleton lose mass and often become fragile and weak causing them to break easily. The elderly may have contractures of the hands (involuntary bending of the fingers and/or wrist) causing great difficulty in feeding themselves.

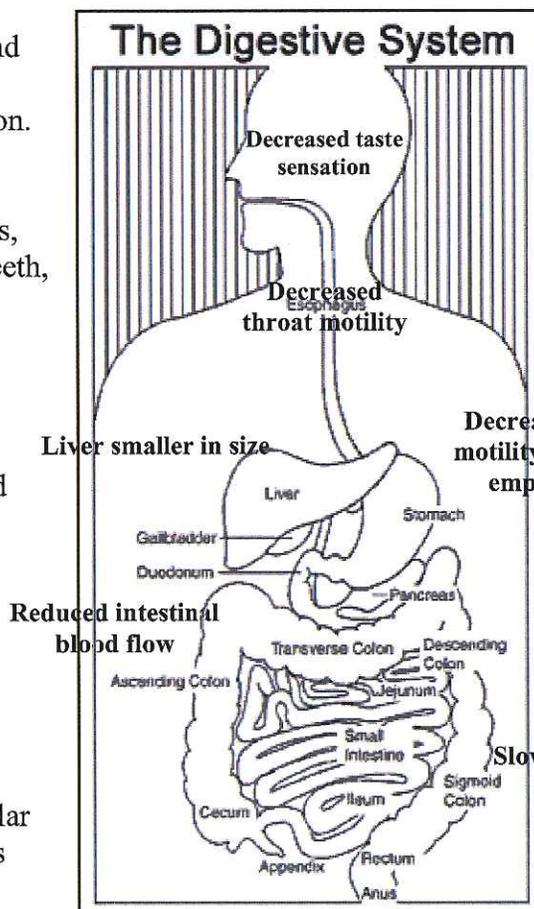
Communication – The inability to communicate and express food preferences or communicate needs at all can be caused by a variety other system failures. Muscle tone, circulation and other problems may cause difficulty swallowing thus potentially the resident could aspirate (breath in) food into their lungs causing pneumonia.

The Digestive System

The digestive system is down food physically and absorbed for use by the process is called digestion. solids wastes from the the digestive tract are: stomach, small intestines, accessory organs are: teeth, liver, gallbladder, and

Digestion begins in the for digestion by the Through chewing teeth cut, chop and grind smaller particles for The taste buds on the contain nerve allow sweet, sour, distinguished. swallowing the tongue pharynx.

The pharynx is a muscular The act of swallowing is contracts. As the throat the esophagus, which is 10 inches long, and empties into the stomach.



responsible for breaking chemically so that it can be cells of the body. This The system also eliminates body. The major parts of mouth, pharynx, esophagus, and large intestines. The tongue, salivary glands, pancreas.

Decreased stomach motility, hunger, and emptying time. mouth. It prepares the food saliva present. motions, the food into digestion and swallowing. surface of the tongue endings. The taste buds bitter, and salty tastes to be During the act of pushes food into the

Slower bowel motility

tube known as the throat. continued as the throat contracts it pushes food into another muscular tube about

The stomach is a muscular, pouch-like sac located in the upper left portion of the abdominal cavity. Stomach muscles churn and stir the food into smaller particles mixed with the gastric juices making a semi-liquid substance called chyme. The chyme is pushed from the stomach into the small intestine

The small intestine is about 20 feet long and divided into three parts. The first is the duodenum, which adds more gastric juices to the chyme. Bile is one of the juices produced by the liver and stored and excreted from the Gall bladder into the duodenum. These juices breakdown the chyme even more so the body can absorb it.

The movement of the substances through the other two parts of the intestine; the jejunum and the ileum, is called peristalsis. Tiny projections along the intestine called villi absorb digested food primarily in the jejunum and ileum. The undigested substances are moved into the large intestine, also known as the colon or large bowel. The colon absorbs most of the water left and the remaining semi-solid substance is excreted as bodily waste or feces.

Chapter 2

Recognizing and Reporting Changes in the Elderly

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Recognizing Changes in Residents

As you feed the residents regularly, you will get to know them. In addition to learning what foods they like and how much help they need, you will get to know about their health and their mental abilities. You will also be able to tell when something is different about a resident. Changes can mean that a resident is getting sick or that something is bothering them. It is important that you report any changes that you notice so that the nurse can assess the resident and do whatever she needs to do to help them.

Objective and Subjective Information

Your observation of a resident is an excellent source of information. There are two types of information: what you observe, and what the resident tells you or what you sense. It is important that you report information accurately.

Objective information is factual information. You observe objective information by looking, listening, feeling, and touching. For example, the statements, “This resident ate 75% of their lunch,” and, “That resident refused to eat breakfast,” are objective data.

Subjective information is your opinion or the way that you interpret a situation. If you see that a resident did not drink any milk at lunch, you might try to interpret that fact. You might guess that they do not like milk. This guess is subjective. It might be right or wrong, but it is not a fact. Maybe the resident likes milk but did not drink it this time for some other reason.

Usefulness of Subjective Information

The subjective information you provide from your observations can be very helpful as long as you identify it as your opinion or as information from the resident. Another example of subjective information is telling the charge nurse that you noticed that a resident “just seems different today.” When the nurse assesses the resident, she finds that they have an infection. Your report of this subjective information helps this resident to get treatment before a serious problem develops.

How to Report Information

You report different information in different ways. Usually you report to the charge nurse, but sometimes you need to report to other staff. When you report information, give the resident’s name and accurately describe what you have observed about the resident.

It is important to keep information about the resident confidential. Give information about a resident only to staff involved in the resident’s care. Use a private place to report, where others will not overhear you. Sometimes you will record information on a **flow sheet** or other document. You do not need to report this kind of information to the nurse unless it is not normal for the resident.

What to Report

As you get to know a resident well, you see little changes that others may not notice. Report anything that is different or not normal for the resident. You may get a feeling that there is something wrong with the resident, but you don't know what it is. You should report this type of observation because the resident might be getting sick or something else might be wrong.

Other things to report to the charge nurse:

- The resident has a change in appetite: refuses to eat or drink, eats very little, eats only certain things.
- The resident avoids any major food group, such as not eating meat or drinking milk, or usually eats less than 75% (or 3/4) of meals.
- The resident experiences a change in eating, such as needing more help with meals.
- The resident behaves differently: playing with food, taking food from other residents.
- The resident has problems with eating: coughing, choking or trouble swallowing, food or fluid coming out of their nose, drooping of one side of their face or food running out of one side of their mouth, trouble chewing.
- The resident has increased agitation or confusion: doesn't sit still, fighting with other residents, or a resident who is normally agitated is suddenly calm and quiet.
- The resident experiences hand tremors that result in difficulty eating.
- The resident has a change in mood, such as becoming withdrawn or angry.
- The resident has dentures that do not fit.
- The resident complains about the food or their diet.
- The resident has physical complaints such as pain, dizziness, nausea, or chills.

What if you don't know if you should report certain information? Report it anyway. It is better to report too much than not enough.

Immediate Reporting

Certain information must be reported immediately. This includes:

- **Any change in a resident's alertness**
- **An emergency such as a fall or bleeding**
- **A change in the resident's condition**
- **Resident complaints such as not feeling well, having pain, or being dizzy**
- **Potential resident abuse**

Signs of Abuse

You will learn more about resident abuse in Chapter 6. Here are some signs of abuse to look for:

- Acting fearful around a particular person
- Pulling back when you raise your hand or move quickly
- Seeming upset but denying that anything is wrong

Intake Measurements

Because residents need adequate food and fluid intake for their health and well-being, intake measurements are important. These measurements help determine whether or not the resident is getting enough to eat.

Evaluating Food Intake

Reporting the amount of food a resident eats is your responsibility. Reporting can sometimes be a challenge because you must describe how much a resident ate when there is food left on the plate. Different facilities have different ways of recording the amounts of food a resident eats. You may record intake as the percentage eaten: 100%, 75%, etc. This report allows the dietitian to calculate the number of calories or amount of protein consumed.

Facilities use many different formats to record dietary intake. Recording intake is somewhat subjective because you must observe the meal and judge the percentage of food the resident eats. Since it is impractical to actually measure the amount of food eaten, a method of estimation is often used. Take the time to evaluate each resident's intake carefully and record the percentage eaten immediately. You might use a pocket notepad and transfer the information to the facility record later.

Evaluating Fluid Intake

Like food intake, adequate fluid intake is vital. Although fluid requirements vary depending on the person's age, size, physical condition, and level of activity, most residents require six to eight glasses or 1500 to 2000 cc of fluid per day. At certain times, such as when the weather is hot or the resident has a fever, the resident may need extra fluid. Residents with heart or kidney disease may not be allowed to have this much fluid because it can cause **edema**, in places like their legs and ankles. These residents are on a fluid restriction. Check the resident's diet card or ask the charge nurse how much fluid the resident can have at each meal. Offer fluids often and encourage the residents to drink, unless they are on a fluid restriction.

You need to know how much fluid is in the glasses and cups in your facility. This information may be on the fluid intake record. You may also ask the nurse or the dietitian for this information.

Recording Fluid Intake

To record fluid intake, you need to know how much fluid is in the containers on the resident's tray, and how much of it the resident drank. Fluids are usually measured in cubic centimeters or cc. There are 30 cc in an ounce. To determine how much fluid is in an eight-ounce glass, multiply the number of ounces by 30.

$$8 \times 30 = 240$$

An eight-ounce glass contains 240 cc. What if the resident only drank half of the fluid in the glass? Half of an eight-ounce glass is four ounces.

$$4 \times 30 = 120$$

Four ounces equals 120 cc.

Recognizing and Reporting Changes
Capacities of Common Containers

| Container | Number of cc |
|--------------------------------------|--------------|
| Water glass—8 fluid oz | 240 cc |
| Juice glass—4 fluid oz | 120 cc |
| Coffee cup—6 fluid oz | 180 cc |
| Styrofoam cup, 3 in. tall—6 fluid oz | 180 cc |
| Ice cream—3 fluid oz | 90 cc |
| Jell-O—1/2 cup | 120 cc |
| Soup bowl—6 fluid oz | 180 cc |
| Cereal bowl—8 fluid oz | 240 cc |
| Individual carton of milk, 8 oz | 240 cc |
| Can of feeding supplement, 8 oz | 240 cc |

Using Flow Sheets

Many facilities record the resident's intake on a flow sheet. Flow sheets have a chart or graph on which you record the information. Some facilities use a single sheet for several residents. Others use a separate flow sheet for each resident.

Measuring Fluids

Using any resident tray in the dining room, measure the total amount of fluid offered to the resident. List each fluid item. Write beside it the total number of cc.

Total the numbers in your list.

Chapter 3

Feeding Assistant Duties

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Feeding Assistant Duties

Assisting Residents with Meals

Your duty as a feeding assistant is to help residents with meals. Although you might think this is a simple matter of common sense, it actually requires a lot of attention. Your ability to do it well directly affects residents' nutritional status. Many residents can eat independently or with a little help from the staff. Other residents, however, need a lot of help or must be fed. These residents depend on the staff to meet their nutritional needs.

Dining Atmosphere

A pleasant atmosphere adds to the resident's enjoyment of their meals. The room should be clean and neat and free of unpleasant odors. Some facilities play background music at mealtime. It should be played softly so it does not interfere with conversation. Select music that the residents enjoy. Noise should be kept to a minimum. Avoid banging trays and plate covers.

Mealtime is more than simply eating food. For many people it is a social time; a time for pleasure; a time for conversation; for enjoying appetizing aromas, sensational tastes and the simple pleasure of appreciation of good food. The company of friends and family adds the social enjoyment of the mealtime and for many residents these things are associated with "home".

However, the many lifestyle changes, which accompany the aging process, can erode an elder's dining pleasure. They may not be able to open packages and use utensils. Their hearing, vision, smell and taste may be altered preventing them from enjoying eating. These changes can put the elderly at risk for not eating and resulting in poor nutrition, which can lead to other health problems.

The dining atmosphere is crucial to creating a pleasurable dining experience. Attractive surroundings, with friends, and being shown dignity and respect, helps maintain that atmosphere. Given the significance of mealtime, every effort should be taken to make each meal a positive experience.

As part of the dining experience the environment, the dining room, should be as home-like as possible. Tablecloths, napkins, flowers, and other types of centerpieces should be present to set the tone for the meal.

Dressing for dinner, combing their hair, or fixing a resident's makeup all contribute to their self-esteem and the anticipation of the meal. It goes without saying that they should have their glasses, dentures in, and hearing aids in to be ready for the meal.

Like most of us, sitting with people we like and have things in common with is important. Seating arrangements should consider groupings that inspire social interaction. It is not appropriate to seat confused, noisy and disruptive persons with cognitively intact folks.

Our attitudes toward the elderly go along way in keeping the mealtime a productive and enjoyable time. If we seek to facilitate skills versus "doing it for them" the resident is maintaining the highest skill level possible which promotes self-esteem. Our goal is to assist the resident to maintain their independence and improve their abilities if possible.

Seating Residents

Residents more fully enjoy their meals when they are properly prepared.

Make each resident as comfortable as possible. Residents should sit upright with their feet touching the floor. Wheelchairs may not be the correct height for the table. If possible, the resident should be transferred from a wheelchair to a dining room chair. Use clothing protectors or napkins to protect their clothing. Do not call clothing protectors "bibs." Doing so violates the residents' right to dignity.

Residents enjoy sitting with their friends. Try to seat newer residents with others who have similar interests. Sometimes family members will join a resident for lunch or dinner if permitted by facility policy. Mealtime can be a special occasion for the resident.

Before serving a meal or feeding a resident, wash your hands thoroughly. This procedure is an important part of infection control.

Some facilities serve each course of the meal from the kitchen when the resident is ready to eat it. The feeding assistant and the server must work together so that the resident does not have to wait a long time between courses and the food is at the correct temperature. In other facilities, trays are made up in the kitchen and brought to the dining room on a cart.

Diet Cards

Each tray has a **diet card** with the resident's name, type of diet, and any special information about the resident such as feeding instructions, allergies or fluid restrictions.

| | |
|---------------------------------|--------|
| Resident's Name | Room # |
| Diet: _____ | |
| Preferences: _____ | |
| Dislikes: _____ | |
| Restrictions: (Allergies) _____ | |
| _____ | |

Check the resident's identification bracelet to be sure you are serving the correct resident.

Serving a Resident's Meal: Some General Suggestions

- Pass out the trays as quickly as possible to be sure cold foods are still cold and hot foods hot.
- Serve all residents at a table before moving on to the next. It is frustrating to watch others eat and maybe even finish their meals while you are still waiting.
- Serve slow eaters first so they have extra time to finish their meal.
- Remove the food from the tray and place it on the table.
- Each tray may have a variety of individually wrapped condiments that may be difficult for the resident to open. These include, butter or margarine, jelly, sugar, salt and pepper packets.
- Season food as the resident prefers and according to their diet. Encourage residents to express their preferences.
- You may need to butter the bread.

- If the resident needs assistance in cutting up food, cut it up into bite size pieces. Meat becomes cold faster once it is cut up so you may wish to cut only part of the meat at one time. You may need to cut a sandwich into smaller pieces also. Perhaps the resident will want you to cut off the crust to make it easier to chew
- In most cases, you will need to open the resident's beverage cartons. You may need to pour the beverage into a glass or cup.
- The resident may use a straw to drink the beverage. Short straws make it easier for weak residents to draw up the beverage.
- Some food needs to be stirred or peeled. Look at the meal and see what needs to be done. For example, you may need to add sugar or sweetener to coffee. You may need to add sweetener and lemon to iced tea. Peel bananas and other fresh fruit as needed.

Visually Impaired Residents

You may have many residents who are visually impaired. For someone who has a severe visual impairment, describe what is on their plate as if it were a clock. Say, "The potatoes are at 12 o'clock, the vegetables at 4 o'clock, and the meat at 8 o'clock.

Return the tray and cover to the service cart.

Need for Assistance

Residents in your facility will require different levels of assistance with eating.

Some will be able to eat with no help at all. You should check on these residents during the meal to see if they need anything and to observe for any problems they may have with eating.

Some residents will be able to do some things but need help with others. They may be able to eat finger food but not be able to use a spoon.

Other residents will need verbal or physical **cuing**. Still others will need to be fed the entire meal. Encourage residents to be as independent as possible, but always offer to assist if the resident is having difficulty.

Proper Positioning for Mealtimes

In preparation for eating, one of the most important factors is proper positioning of the resident. Many elderly residents in a nursing facility don't have major problems with sitting at a table and eating. However, some do and here are some things to look for as you get a resident ready for their meal.

- ◆ Is their head slumped forward.
 - ◇ should be held up with a slight tilt forward..
- ◆ Are their shoulders rounded.
 - ◇ should be back as much as possible, makes breathing easier.
- ◆ Are their feet touching the floor or supported by foot pads on a wheelchair.
 - ◇ feet should not dangle.
- ◆ Are their elbows unsupported.
 - ◇ should be supported to provide leverage.
- ◆ Are they sliding back or forward in the chair.
 - ◇ should be sitting up with their bottom against the back of the chair.
- ◆ Is the table height at about the waist or a little higher.
 - ◇ make sure wheelchairs can be pulled close to the table.
- ◆ Is their food within about a 12 inch reach.
 - ◇ should not have to stretch to get to their food.

Feeding the Resident

“Patience will achieve more than force.”

Edmund Burke

The key to being a successful feeding assistant is ***patience***. It is not unusual for it to take as long as an hour to feed some residents. Your job is to ensure they eat all that they want to eat.

Sit down next to the resident. If you are right-handed, sit on the resident’s right side. If you are left-handed, sit on the resident’s left side. This makes it easier for you to place the spoon in the resident’s mouth. Never feed a resident while standing up. The resident should be able to see you during the meal. If you are feeding two residents at the same time, be sure to keep their dishes and silverware separate.

If you are setting up a visually impaired resident who is capable of feeding themselves, use the clock face to describe to them where and what each item is in relation to the numbers on the clock face, i.e., your fork is at 9 o’clock. Your coffee is at 2 o’clock.

Feed residents in a manner as close to normal as possible to preserve their dignity. Residents should have enough time to finish their meal. If a resident feels that they are being rushed, they may not chew their food enough, or they may eat less and not get the nutrition they need. The meal will also be less enjoyable for the resident.

Encourage the residents to feed themselves as much as possible. They may be able to eat finger foods, such as bread and fruit. Meat can be served on a sandwich and broth can be put in a cup for the resident to drink.

- Let the resident decide what to eat and in what order.
- Use a spoon from which the resident can easily remove the food: usually a teaspoon. Fill the spoon no more than half full.
- Place the spoon on the mid-portion of the tongue and press down slightly.
- Slowly remove the spoon and, if necessary, manually gently close lips with your fingers.
- In some cases you may have to gently control the lower jaw with your fingers at the chin and under the chin.
- Do not rush the resident. Allow enough time for them to chew and swallow the food before offering more.
- Offer more nutritious foods first.
- Offer liquids between bites to keep their mouth moist.
- Be aware of food temperatures. If the food seems too hot, give it time to cool.
- Never blow on the food to cool it. This could spread germs to the resident.
- Do not mix foods together unless the resident prefers it.

- Get a substitute for food the resident does not like or cannot eat. A resident should never leave the dining room hungry. Getting a substitute also shows your caring attitude.
- Save dessert until last if possible.

After the meal

When the resident is finished eating, clean their face and hands as needed.

Before leaving the resident, ask yourself:

- ◆ Have I done all I can to encourage this resident to eat?
- ◆ Have I provided the best nutrition possible?

Remove the dishes and record how much was eaten. Report any changes or problems, such as nausea, choking, or decreased appetite, to the charge nurse.

Cuing or Prompting

Some residents need verbal or physical cuing to help them feed themselves.

Give verbal cues one at a time:

- Pick up the spoon
- Get some potatoes on the spoon
- Raise the spoon to your mouth
- Place the spoon in your mouth
- Close your mouth
- Take the spoon out of your mouth
- Chew the potatoes
- Swallow the potatoes
- Allow the resident to complete one action before starting the next.

Physical Cuing

Physical cuing involves placing your hand over the resident's and guiding them. Verbal cues are combined with physical cuing to help the residents to feed themselves. First tell the resident what to do and then provide a physical cue. Residents may be able to place the spoon in their mouth once you help them to raise their hand. Allow residents to do as much as possible by themselves.

Examples:

Here is your spoon.

Place the spoon in the resident's hand

Get some potatoes on the spoon

Place your hand over the resident's hand and help them to get potatoes on the spoon

Raise the spoon to your mouth.

Guide the resident's hand to their mouth.

Place the spoon in your mouth.

Guide spoon into resident's mouth.

Close your mouth. Please take the spoon out of your mouth.

Help resident remove the spoon from the mouth.

Feeding Someone with a Stroke

The feeding assistant may feed a resident who has had a stroke if the resident does not have any complicated feeding problems. If you think the resident may have dysphagia, stop immediately and report it to the charge nurse.

- Position yourself on the unaffected side
- If one side of the face is weak, place food in the opposite side of the mouth
- Encourage the resident to self-feed
- Use assistive devices, if ordered
- Provide assistance with controlling the spoon or raising the hand as needed

Residents with Dysphagia

Residents with **dysphagia** have difficulty or discomfort when swallowing.

Symptoms of dysphagia include:

- Coughing before, during, or after swallowing food, liquid, or medications
- Needing to swallow 3 or 4 times after each bite
- A hoarse, breathy voice or gurgling breathing
- Drooling
- A feeling that something is caught in the throat
- Pocketing food in the side of the mouth
- A repetitive rocking motion of the tongue from front to back
- Continuous throat clearing

Preventing Aspiration

Special care needs to be taken when feeding these residents to prevent choking and aspiration.

Important!

Feeding assistants are ***not*** permitted to feed residents with dysphagia. If you think that a resident you are feeding may have dysphagia, stop immediately and report your observations to the charge nurse.

Assistive Devices

Residents who have difficulty feeding themselves may benefit from using special spoons and forks, cups, and other items. These items are called **assistive devices** or adaptive equipment. Residents need to be taught to use these devices. Usually the **occupational therapist** teaches the resident and staff how to use them. If you think one of the residents could eat better if they had an assistive device, talk to the charge nurse.

Assistive devices used for eating include:

- Non-skid mat—prevents dishes from sliding on table
- Plate guard—a metal or plastic rim that attaches to the plate to prevent food from being pushed off the edge
- Scoop bowl—prevents food from being spilled over edge
- Lidded cup—prevents spilling. Also keeps liquid from flowing into the resident's mouth too quickly
- Cutout cup—for a resident who is unable to bend the head backwards
- Glass or cup holder—for a resident who is unable to grasp a glass or cup

- Built-up handles—placed on handle of forks and spoons for residents who cannot close their fingers around regular handles
- Weighted forks and spoons—provide better control for resident with hand **tremors**.
- Wrist weights-- provide better control for resident with hand tremors.
- Angled fork and spoon—for residents who can't bend wrists
- Rocker knife and rocking T-knife—allow resident to cut meat using one hand

Feeding Bed Ridden Residents or Resident Preferring to Eat in Their Room.

Residents may wish to remain in their rooms to eat or may be confined to their bed for a variety of reasons. Whether it is illness or choice, the feeding process is essentially the same with a few additional points to be considered.

Preparation for the meal

The resident in bed or desiring to eat in their room deserves all the same considerations and actions of the resident who eats in a dining area. Because they are in their own room the feeding assistant shall be alert to the environment of the resident's room. Bedpans, urinals and other materials that could impact the residents desire to eat are to be removed but readily available in case the event they are needed.

A reminder here; this is the resident's home and before you enter the room, you must first knock on the door and wait till the resident invites you in. If you know the resident is not communicative, knock, wait a second, then enter announcing who you are and what you are going to do. *"Hi Ms _____, I'm Sandy, I'm here to help you with your meal today."*

If you can, ask if they need to use the bathroom facilities or bedpan, etc. If they do, get a GNA or a nurse (who is there to introduce you to the resident, the first time) to help the resident. Ideally, staff will have done all the preliminary work as you, the feeding assistant, are not permitted to assist the resident with anything but with the meal itself.

- Know where the residents emergency call cord is and place it where you can reach it quickly in the event it is needed. Do not leave the resident in an emergency but use the call light and also yell for help.
- Give the resident a wash cloth and towel to wash their hands and dry them before the meal.
- Have the staff raise the head of the bed to the appropriate height to ensure safe food swallowing.
- Position yourself as you would when feeding a resident in the dining area.
- The meal tray is set up the same as you would in the dining room, depending on the needs of the resident.
- If you can, sit down. Standing can be intimidating especially if you are significantly larger person than the resident.

After the meal, clean the resident's hands and face. Be sure their call light cord is where they can reach it easily. Ask the resident if there is anything else they need before you leave the room. Cordially wish them a good day and say good bye.

Resident Behaviors During Meals

Here are some typical resident behaviors that you will need to respond to.

1. The resident refuses to eat

- Ask them why they are refusing.
- Encourage, but do not force, the resident to eat.
- Offer favorite foods.
- Move the resident to a quiet place with fewer distractions.
- Provide between meal snacks.
- Consider whether the resident's mouth is painful.

2. The resident doesn't open the mouth

- Ask the resident to open their mouth.
- Gently touch the spoon to the resident's lips.
- Yawn. This may cause the resident to yawn also.

3. The resident bites down on the spoon

- Ask the resident to open their mouth.
- Wait until the jaw relaxes. Do not try to pull the spoon out of their mouth.
- Do not use plastic spoons for these residents. The spoon could shatter, causing injury.

4. The resident eats with his hands

- Place the spoon in the resident's hand.
- Provide finger food.

5. The resident holds food in the mouth

- Remind the resident to chew and swallow.
- To trigger swallowing, gently press down on the tongue when removing the spoon from the resident's mouth, or gently press down on the top of their head with your hand.
- Check to see that resident has swallowed before offering another bite.

6. The resident pockets food in the cheek

- Remind the resident to chew and swallow
- Touch side of cheek and tell resident to use tongue to get food
- Place fingers on outer cheek at lower jaw and gently push food toward teeth

Chapter 4

Feeding Residents with Dementia

Chapter Four Feeding Residents with Dementia

What is Dementia?

Dementia is a loss of mental functions such as memory, thinking, and reasoning, caused by changes in the brain. Dementia is not a disease but a group of symptoms. Changes in personality often occur with dementia. Sometimes dementia can be cured, such as when it is caused by drugs, alcohol, or poor nutrition. In other cases the dementia cannot be cured, such as when it is caused by **Alzheimer's disease**. (The word dementia means away from the mind. It comes from the Latin word *mens* or mind and the prefix *de*, which means away.)

Cognitive impairment is a temporary or permanent change in thinking. Normally you can learn and remember things with your cognitive abilities. Your cognitive abilities help you live a productive life. When a person is cognitively impaired, however, they may have more than just memory loss.

Cognitive impairment is also a disruption in knowledge, memory, awareness, or judgment. Cognitive impairment has many causes. Temporary causes include stress, medications, depression, a vitamin deficiency, thyroid disease, alcohol, or head trauma. Permanent causes include severe head trauma, illness, brain disease, or brain damage at birth. In long term care facilities, most cognitive impairment is caused by brain disease.

| Various Forms of Dementia | | |
|----------------------------------|---|--|
| Disease | Features | Course |
| Alzheimer's Disease | Presence of neurofibrillary tangles, neuritic plaques | Onset age: 60-80 Slowly progressive |
| Multi-infarct Dementia | Obstructed blood flow in the brain cells due to arteriosclerosis or atherosclerosis | Onset age: 55-70 Damage determines severity |
| Huntington Disease | Genetic disease | Onset age: 25-45 Duration 15 years |
| Parkinson's Disease | Deficient dopamine in the brain | Onset age: 55-60 Several years duration |
| Creutzfeldt-Jacob Disease | Non-inflammatory virus causes changes in the brain | Onset age: 50-60 Rapidly progressive |
| Syphilis | Spirochete (bacteria) causing brain damage | Occurs 15-20 years after primary infection |
| AIDS Dementia | HIV-1 infection | Symptoms sometimes precede diagnosis of AIDS |

What Causes Dementia?

- o Degenerative diseases of the nervous system, such as Alzheimer's and Parkinson's disease
- o Conditions that affect the blood supply to the brain, such as stroke or multi-infarct dementia, which is a series of small strokes.
- o Toxic reactions, such as from excessive alcohol or drug use

- o Nutritional deficiencies, like vitamin B12 or folic acid deficiency
- o Infections that affect the central nervous system, such as AIDS dementia complex
- o Head injury—either a single severe head injury or smaller injuries over time

What is Alzheimer's Disease?

Alzheimer's disease is named after Alois Alzheimer, the German doctor who first identified it in 1906. With Alzheimer's disease, abnormal changes occur in nerve cells in the part of the brain that controls thinking and memory. Over time, these changes spread to other parts of the brain, affecting the part of the body controlled there.

The disease affects people of all ages, races, levels of intelligence, education, and financial status. It is progressive and there is no cure. People who are diagnosed with Alzheimer's disease usually live about seven years. Alzheimer's usually occurs in older people and is the fourth leading cause of death in adults over age 65. People who have family members with Alzheimer's have a greater risk of getting the disease themselves.

There are no diagnostic tests. When symptoms appear, the individual should go to a physician to rule out other causes of disordered brain function such as depression, various medications, or nutritional deficits. These and some other causes can be reversed. Alzheimer's disease cannot, at this time.

Alzheimer's disease is divided into three stages: early or mild, middle or moderate, and late or severe. These stages may overlap, with the resident having symptoms of two different stages at the same time. Understanding the different stages helps you know how to support residents and how to meet their needs.

Behavioral Symptoms of Alzheimer's Disease

A resident with Alzheimer's disease may have both cognitive and behavioral symptoms. Cognitive symptoms include memory loss, disorientation, confusion, and problems with reasoning and thinking. Behavioral symptoms include agitation, anxiety, delusions, depression, hallucinations, insomnia, and wandering.

Understanding People with Alzheimer's Disease

Residents with Alzheimer's disease often live in the past. An 85-year-old resident may tell you that his mother is coming to visit today. You know that his mother died many years ago. However, if you say this to the resident, he will become very upset and may not believe you. In his mind, he is a younger person who is expecting a visit from his mother. He is not able to put himself in the current world. When this happens, you can go to where the resident is and validate what he is saying. Ask questions such as, "What color is your mother's hair?" that show the resident you are interested.

Stages of Alzheimer's Disease

Stage I (mild): Symptoms include, but not necessarily limited to:

- Less initiative and drive
- Anxiety, depression, and agitation
- Problems finding words
- Short-term memory loss
- Person may be aware there is a problem
- Appears self-absorbed, insensitive

Feeding Residents with Dementia

- Difficulty planning or making decisions
- Unable to make calculations
- Seeks and prefers the familiar, shuns unfamiliar
- Changed ability to show feelings, control temper, handle frustration
- Difficulty remembering how to get from one place to another
- Confusion
- Lack of safety awareness
- Personality changes
- Judgment problems
- Difficulties with routine tasks
- Gets lost or disoriented in familiar places
- Delusions of persecution

The Resident in the Early Stages

When first meeting a person in the early stage you may not realize that there is anything wrong with them. They look and act pretty normal and are often quite pleasant. However, as you get to know them, you may begin to notice problems with words and memory. They may become confused and have difficulty making decisions. There may also be changes in their personality.

Stage II (moderate): Symptoms include, but not necessarily limited to:

- Difficulty with activities of daily living (ADL)
- Behavioral changes (sleep disturbances, insomnia, wandering, pacing, anxiety, agitation, paranoia)
- Disoriented regarding time, place, and person
- Problems understanding others and speaking and writing
- Problems with judgment
- May not recognize familiar people
- Repetitive actions
- Sundowning, the increase of confusion and restlessness unusually occurring in the late afternoon, early evening and at night.
- Great difficulty making decisions
- Inappropriate responses to situation
- Poor or failing memory of recent past
- Memory of distant past astonishing clear
- Lethargic, seems cold to others, indifferent

The Resident in the Middle Stages

In the middle stage residents may no longer care about their appearance. They may wear clothing that doesn't match and fight when their caregiver tries to give them a bath or comb their hair. They may not recognize familiar people such as family members. They may begin to develop aphasia, a problem with speech and understanding language.

Stage III (severe): Symptoms include, but not necessarily limited to:

- Unable to communicate
- Unable to care for self, complete dependence on caregiver
- Poor long-term and recent memory
- Assumes fetal position

- Loss of speech
- Loss of appetite
- Loss of bladder and bowel control
- Eventual shut down of mind and body

A Resident in the Late Stages

In the late stage of Alzheimer's, the person loses the ability to sit up, to hold up their head, and to swallow. They do not communicate at all.

Balance is affected and they may shuffle their feet when they walk. They will remember things from long ago but not what happened a few minutes ago. Sometimes they will follow you around just because they want to be with someone.

In this last stage, the body gradually shuts down and the person dies.

Feeding Assistance for Residents with Dementia

Working with people with Alzheimer's disease or any dementia is challenging, rewarding, and gratifying. All caregivers must be compassionate, patient, calm, and have a sense of humor.

The amount of guidance and direction needed depends on where the resident is in the disease process. Help them focus on the task they are trying to do. Residents with Alzheimer's do not like changes in their routine. Seat the resident at the same place for all meals. If your facility allows residents to select from a menu and the resident is capable of doing so, help them to make their choices before bringing them to the dining room. These residents may have trouble making decisions. Limit their choices so that decision making is easier. Allow them to choose between two items. Say, "Would you like ham or chicken?" If they start to become upset or frustrated, you should make the choices for them. Do not seat them until you are ready to serve their meal.

A resident with dementia may take things from another resident's plate. If possible, seat them with other residents who have dementia.

Make sure these residents' meals are ready to eat as soon as the food is served. The meat should be cut, the cream in the coffee, and the butter on the roll. Cups and glasses should be only partially full to prevent spilling. Be sure that the food is not too hot. Do not serve dessert until they have eaten the meal.

Cuing the Resident with Dementia

The resident should be encouraged to do as much as they can without assistance. Some residents will need to be told to pick up the spoon, get food on it, and place it in their mouth. This process is called cuing. If they are no longer able to use a spoon, they should be given finger food.

Residents with Alzheimer's disease often misinterpret things around them. They may not understand what you are asking them to do or why. They may become frustrated, upset, defensive, or agitated. Behavioral symptoms like outbursts and tearfulness often show the resident is in distress. Finding and removing the cause of this distress or threat is important to the resident. This also makes your job easier and your time with the resident more enjoyable.

How You Can Help

- Be positive, polite, and enthusiastic about them.
- Compliment their dress or how their hair looks.
- Mention things you know about the resident's past, like being a great cook.
- • Try to bring out positive emotions.

To care for residents, you need to know them well. How do they like things done? How did they do things in the past? Gather as much information as you can to help understand them. Ask questions of a resident, other staff members, and family members and friends. Be mindful and discover their routine.

Consider these questions:

What did they do for a living?

What is their religion?

Did they have any hobbies?

What is their social background?

What were they proud of?

What made them feel sad?

Did they experience major losses?

What were they afraid of?

How did they handle stress?

What was a typical day like for them before their illness?

Also consider,

What behavioral symptoms do they have?

What stage of illness are they in?

This information helps you enter their reality and makes your care giving easier. Often a resident still tries to follow a past routine. Disrupting this routine causes stress. Knowing their routine, and honoring it when you can, helps the resident feel positive.

Chapter 5

Nutrition and Hydration

Chapter Five Nutrition and Hydration

Nutrition: The entire process by which the body takes in food for growth and repair and uses it to maintain health. Signs of good nutrition include, but not limited to:

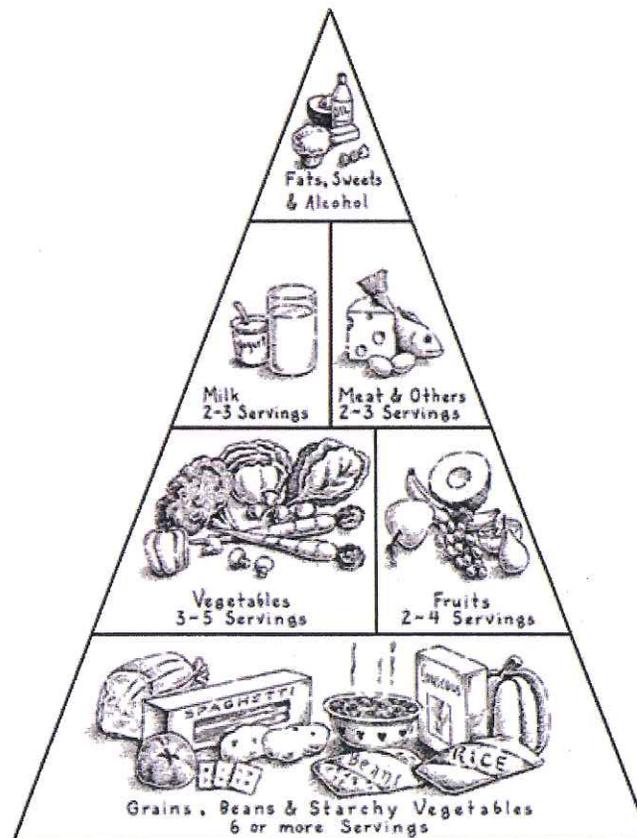
- | | | |
|-------------------------|--------------------------|---------------------------|
| ◇ Shiny hair | ◇ An alert expression | ◇ Regular bowel habits |
| ◇ Clear skin | ◇ A pleasant disposition | ◇ Good appetite |
| ◇ A well-developed body | ◇ Healthy sleep patterns | ◇ Height – weight balance |

Nutritional Needs of the Elderly

People of all ages have important nutritional needs. Throughout the day, they select foods that they like, or that they can afford. As people age, however, their nutrition needs change and the risk of malnutrition increases.

There are many body functions that slow down as part of the aging process. Changes are not the same from person to person but older people are more likely to have problems that affect their eating habits and nutrition.

The Food Guide Pyramid



Recommended Dietary Allowances for people over 50 (not a complete list)

| | Men | Women | | Men | Women |
|----------------|------|-------|-----------------|-----|-------|
| Calories | 2400 | 1800 | Vitamin E (iu) | 12 | 12 |
| Potassium (gm) | 2 | 2 | Vitamin C (mg) | 90 | 90 |
| Zinc (mg) | 12 | 12 | Thiamin (mg) | 1.2 | 1 |
| Iron (mg) | 10 | 10 | Riboflavin (mg) | 1.4 | 1.2 |
| Calcium (mg) | 1000 | 1200 | Niacin | 19 | 14 |
| Vitamin A (mg) | 1000 | 800 | VitaminB6 (mg) | 2.2 | 2 |
| Vitamin D (mg) | 600 | 600 | VitaminB12 (mg) | 3 | 3 |

| Nutrient Class | Function | Food Sources |
|---------------------------|---|--|
| Carbohydrates | Provides energy for work | Cereals, grains, and their products, bread, pasta, potatoes, sugar, syrup, fruits, milk, vegetables, and nuts. |
| Proteins | Build and renew body tissue, regulates body functions and supplies energy | Animal fats – meat, milk, eggs, fish, cheese, and poultry, Vegetable foods – soy beans, dry beans, peas, some nuts, and whole grain products |
| Fats | Gives work energy for body activities and heat energy for maintenance of body temperature | Lard, vegetable fats, oils, and butter. Fats are also found in meats, cream, nuts, etc. |
| Minerals and Calcium | Builds and renews bones, teeth, tissues, blood cells, and nerves | Milk products, meats, vegetables, fruits, beans, cereals, and salt fortified with iodine |
| Vitamins | Aids body in absorbing proteins and using calcium and phosphorus. Helps maintain normal functions of muscle, nerves, heart, and blood | Milk, meat, poultry, nuts, breads, grains, eggs, vegetables, and fruits. |
| Water (has no food value) | Regulates body processes and temperatures, carries nutrients to body cells, and carries waste products away | Drinking water and other beverages; Examples are milk, soups, vegetables, and fruits. |

Components of a Healthy Diet

A healthy diet consists of a daily supply of vitamins, minerals, protein, carbohydrates, fats, and fiber.

The USDA recommends that each person eat five servings of a variety of fruits and vegetables every day. Health experts recommend 20 to 35 grams of fiber per day. The best sources of fiber are fruits, vegetables, legumes (dried beans), and whole grains.

A good diet is based on moderation and variety. Variety means eating foods from each of the five food groups each day (1) breads, cereals, and grains; (2) fruits; (3) vegetables (especially green and yellow); (4) meat, poultry, fish or alternatives; and (5) dairy such as milk, cheese, or yogurt.

Good sources of protein in addition to meat, poultry and fish, are beans, eggs, and nuts.

Changes in Metabolism

Older people generally have a slower metabolism than they did when they were younger. They are also not as active. They do not burn as many calories so they need less food. Older people do not need as many calories but they need just as many nutrients. Their food should be nutrient dense. This kind of food has lots of nutrients but few calories.

Loss of Appetite

Food and nutrition are an important part of life. When people age or become ill, however, their appetites often change, creating a challenge for their care. A healthy person feels hungry and enjoys eating food and drinking beverages. Poor appetites are common among residents of long-term care facilities.

Common causes of poor appetite are: medications, sensory changes, reduced exercise, and depression. Nursing facility staff can help a resident improve appetite by serving smaller portions, serving a variety of foods, increasing exercise, and making meal time a pleasant social occasion.

Therapeutic Diets

A **therapeutic diet** is a special diet that is a treatment for a disease or condition.

Examples:

- A low sugar or carbohydrate diet for someone with diabetes
- A low sodium (salt) diet for someone with high blood pressure
- A low calorie diet for someone who is overweight
- A low cholesterol diet for someone who has high cholesterol
- A mechanical diet for someone who has difficulty chewing.
- A pureed diet for someone who can't chew at all and may be a high risk for choking.

Other Special Diets

Renal Diet: For the resident with chronic or acute kidney failure. The diet contains reduced amounts of sodium (salts) and potassium.

Clear Liquids: This diet contains only fluids you can see through and is used during times of illness such as flu, diarrhea and/or vomiting. Examples of fluids may be jello, juice, water, ice and popsicles.

Full Liquids: The full liquid diet consists of foods that are primarily liquid at room temperature. Examples include: All clear liquids and milk, juices, custard, ice cream, yogurt, strained soups are a few.

Lactose Intolerance: Many older people are **lactose intolerant**. A person who is lactose intolerant cannot digest the sugar (lactose) found in milk and milk products. The reason is a deficiency in lactase, the enzyme that helps people digest lactose. Symptoms include bloating, intestinal gas, abdominal cramping, nausea and diarrhea. There are pills to take when consuming dairy products and drops that are placed in milk that help to prevent these symptoms. The facility may provide lactose-free milk for residents who are lactose intolerant. Many people who are lactose intolerant can eat yogurt and hard cheeses.

Nutritional Supplements: Residents whose nutritional intake is poor may have additional foods ordered for them. These supplements can take the form of additional foods such as ice cream, sandwiches, and milk or may be high protein drinks. Any foods over and above the usual meal are considered “supplemental”. It is important that these are taken by the resident and if refused, the charge nurse must be told.

Other Special Diets and their Requirements

A **vegetarian** usually does not eat meat or poultry. Some vegetarians eat fish. Some do not eat eggs or dairy. There are many different types of vegetarian diets. If a resident does not eat meat, it is important to honor that decision. For many people diet is part of their religious practice.

Kosher Diets: If a resident wants a kosher diet, the facility will need to prepare or purchase foods in special ways. The facility also needs to understand kosher rules such as not mixing meat and dairy at the same meal. A feeding assistant does not need to be an expert in kosher foods but they need to understand that there are certain foods such as pork and shellfish that the person will not eat under any circumstances. They need to respect the resident’s right to follow this religious practice.

Other Religious Restrictions: Muslims also do not eat pork. Mormons do not drink any beverages with caffeine. Hindus do not eat beef. It is important to find out enough about the residents you are assisting to know what their dietary preferences are.

Food Allergies

An allergy is a reaction to generally harmless antigens. The reaction can be itching, skin rash, breathing difficulty, diarrhea, nasal irritation, sinusitis, and throat spasm. Common foods that cause an allergic reaction are milk, nuts, eggs, wheat, and corn. Allergic reactions range from mild to severe. In some cases the allergy can be life threatening. If a resident has a severe allergy, it is probably known by the time they enter a long-term care facility and will be noted on the resident’s diet card.

Medication-Nutrition Interactions and Effects

Certain foods may change the way a medication works in the body.

- The effects of the medication may become stronger. This could cause problems like those that occur when too much medication is taken.
- The effects of the medication may become weaker or it may not work at all.
- There could be a reaction between the food and medication that could make the resident ill. Some of these reactions can cause death.

Medications may interact with various types of food, such as grapefruit, broccoli, and cheese. Many medications also interact with alcohol. In some long-term care facilities, residents are permitted to have wine with dinner, a glass of beer, or a mixed drink. The diet card should list foods and fluids that the resident is not allowed to have. It is important to always check the resident’s diet card for before serving meals. Some medications must be taken with food prevent stomach upset or other problems. Others are to be taken on an empty stomach.

Understanding Hydration

In addition to food, people need plenty of fluids every day. Residents must take in enough fluids to keep their bodies healthy. Hydration means maintaining adequate fluid in the body. Diseases that cause mental or physical decline can reduce a resident’s ability to recognize or express their

thirst. If a person does not drink enough fluids, regardless of whether they are healthy or sick, a very serious condition called dehydration can occur. The recommended minimum amount of fluid intake is 1500cc or 50 ounces of fluid per day.

Causes of Dehydration

Many factors can contribute to dehydration, including:

- A resident's reduced ability to recognize thirst
- A decrease in the kidneys' ability to retain fluid when needed
- A resident's inability to communicate the need for fluid because of their mental status
- Medications such as laxatives and diuretics

Signs of Dehydration

Dehydration can occur quickly in an elderly resident. The signs and symptoms of dehydration may include:

- Not drinking at least 6 cups of fluid per day
- Sudden confusion
- Dry or cracked lips
- Dry eyes and dry mouth
- More sleepiness than usual
- Change in ability to do tasks
- Frequent falls
- Changes in amount and color of urine

What to do if there are signs of dehydration

If you notice any of these things in a resident, report it immediately. This is an emergency situation that requires treatment.

The following examples illustrate how quickly a person can become dehydrated:

If a resident is thirsty but shows few signs of dehydration, they may already need fluid replacement equal to 2% of their body weight. A 70 kg (154 lb) man would need 1400 cc (almost six eight-ounce glasses) at this point.

If this resident has consumed no water for three or four days, has a dry mouth, and little urine output, fluid needed may be equal to up to 6% of body weight, or 4200 cc (17 eight-ounce glasses).

Two Common Diet Related Illnesses in Long Term Care

Diabetes

Diabetes mellitus is a condition in which the body is unable to process sugar and carbohydrates. Residents may have either Type I diabetes or Type II diabetes. In Type I, the pancreas produces little or no insulin, a hormone that enables the body to use glucose (sugar) for energy. The resident receives insulin by injection (shot). In Type II, the muscles are unable to use the insulin that the body produces. This disease is treated with medication and diet. In some cases, the person will also require insulin shots. Type II is more common than Type I, especially among older people. Both types of diabetics need to control the amount of sugar and other carbohydrates they consume and should have regular exercise.

Hypertension (High Blood Pressure)

Hypertension is a condition in which a person's blood pressure stays above the normal healthy range. There are many complications of hypertension, including swelling of the feet and legs, problems with the eyes or kidneys, and stroke. Sodium can cause the body to retain fluid so people with hypertension are usually on a low salt diet. They may also be on a restricted calorie or low cholesterol diet.

Foods with high amounts of sodium include: bacon, sausage, canned soups and vegetables
Foods with high amounts of cholesterol include shellfish, red meat, and animal fat such as butter.
Low saturated fats such as olive oil and canola oil are recommended.

Chapter 6

Infection Control

Chapter Six Infection Control

What is an Infection?

A microorganism is a small living plant or animal that can only be seen with a microscope. Microorganisms are everywhere: in the air, on the ground, on our skin, inside of our bodies. We need some microorganisms to stay alive and healthy. For example, certain microorganisms are needed for digestion. Others can cause illness. Microorganisms that cause illness are called pathogens (germs). The illness they cause is called an infection. The microorganisms that cause infection may be present without causing an infection. However, when they multiply and exist in large numbers or travel to a part of the body where they do not belong, infection occurs.

An infection may occur in one part of the body or involve the whole body. A person with an infection usually has symptoms. Some of the symptoms are: fever, pain or tenderness, fatigues, loss of appetite, nausea, vomiting, diarrhea, rash, sores on mucous membranes, redness, swelling, or discharge or drainage from the infected area.

Types of Microorganisms

Scientists group microorganisms that have similar characteristics. Three different types of microorganisms cause most infections.

- Bacteria are microscopic plant life that consist of a single cell and multiply rapidly under the right conditions. Bacteria in food are a major cause of food-borne illness.
- Viruses are extremely small microscopic organisms that grow in living cells. They cause colds and flu as well as hepatitis and AIDS.
- Fungi are plants that live on other plants or animals, such as yeasts, and molds. Athlete's foot is a common fungal infection.

The Importance of Infection Control

People die every day from infections in health care settings. Many infections can be prevented. The challenge in a long-term care facility is to provide a healthy environment for both residents and staff. Infections spread because of careless infection control practices. Simple hand washing and common sense can often prevent this.

Residents are at High Risk for Infection

Residents who are elderly and frail or weakened by illness are more likely to develop infections. Their immune systems are not as strong as those of a younger person so infections are much more dangerous. The same virus that causes a cold in a young person can lead to pneumonia or death in the elderly.

How Does Age Affect Risk?

The elderly have a variety of problems that increase their risk of infection. Skin becomes thinner and more fragile with age, often resulting in open areas. Residents who are unable to move are at risk of getting a **decubitus ulcer**. These conditions provide a doorway for pathogens to enter. Many elderly residents have **respiratory** problems, making them more susceptible to colds and pneumonia. Diseases such as diabetes and cancer are known to increase the risk of infection. You have a very important role in preventing and controlling infections in residents.

The Risk of Long Term Care Living

In recent years the problem of infection has increased in long term care. Residents are grouped closely together, making it easy for infection to spread. Some residents have falls or illnesses that require them to go to the hospital. Often, they return to the facility with an infection.

How are Infections Spread?

Infections spread when one person transmits microorganisms to another. This can occur in several ways:

- Direct contact, usually with hands, is the most common method. Health care providers go from person to person, often serving as sources of infection by direct contact.
- Contact with a contaminated article. Microorganisms can be picked up from a drinking glass, a wheelchair, or a resident's bed.
- Droplet transmission occurs when microorganisms in tiny particles of liquid, called droplet nuclei, are inhaled. Droplets containing a cold virus are put into the air by coughing, sneezing, and talking. Droplets can travel about three feet.
- Airborne spread involves droplet nuclei that are very light and can travel throughout the facility on air currents. Tuberculosis is airborne. Facilities must have a special room that prevents the air from going into the rest of the facility for residents with active tuberculosis.
- Insects can spread microorganisms by touching food that is then eaten, or by biting. Flies, ticks, and mosquitoes are common sources of infection.

Colds and Flu

Did you ever wonder why colds and flu are more common in the winter? People used to think that being cold made it easier to catch a cold, but that has been proven wrong. Colds are more common in the winter because people stay inside more, often in closer contact with each other. Windows are kept closed, preventing fresh air from entering. The viruses that cause colds are more easily spread among people in close contact, who are coughing and sneezing. Anyone can catch a cold at anytime, but for the elderly living in facilities, the risk is much higher.

The Importance of Food Sanitation

Food sanitation practices prevent food from becoming a source of illness. This includes using clean equipment for preparation, adequate refrigeration for storage, and proper hand washing, especially after using the bathroom, coughing, or sneezing. If food sanitation is not maintained, large numbers of people can become ill from eating contaminated food.

Food-borne illness, commonly known as food poisoning, is a major problem for people of all ages. There are millions of cases of food-borne illness in the United States each year. Only a fraction of the cases is reported. Food-borne illness results from eating food infected by bacteria. Bacteria begin multiplying within 2 hours when food is at room temperature.

Symptoms of Food-borne Illness

The most common symptoms are:

- Diarrhea
- Fever
- Nausea
- Vomiting
- Weakness

Characteristics of the Elderly Affecting Risk for Food-borne Illness

Older people are at great risk for food-borne illness for several reasons.

- Their immune systems are weaker and they often have chronic health problems.
- The sense of taste and smell declines with age and reduces the resident's ability to tell whether or not a food is safe to eat.
- In a long-term care facility, there are more people handling and preparing the food.

Prevention Tips for Feeding Assistants

- Check foods before feeding. If something looks or smells bad, do not give it to the resident.
- Serve and feed the residents promptly. Do not allow cold food to become warm or hot food to become cold.
- Be on guard for problems with foods and if in doubt, speak to the charge nurse.
- Wash your hands before and after feeding each resident.
- Wash your hands if you sneeze or cough during feeding.
- Keep table surfaces clean. Be sure the table is clean before putting down a tray or bringing a resident to the table to eat.
- Don't allow a resident to eat or drink from another resident's plate or glass.

Taking good care of yourself can prevent both you and the residents from getting sick. Here are some things you can do for yourself:

- Eat a balanced diet. Do not skip meals or fill up on snack food.
- Get plenty of rest. You need seven or eight hours of sleep each night.
- Learn to manage stress. Stress can weaken your immune system.
- Avoid people with colds and other infectious diseases whenever possible.
- Get a flu shot each fall.

Stopping Infection Before it Starts

Annual "flu shots" should be given to both residents and staff. However, elderly residents often have weakened immune systems and may not be protected by the flu shot. That makes it even more important for you to get one, so that you do not give the flu to the residents.

The best way to protect yourself from infectious diseases is to be immunized against those diseases that have vaccines, stay as healthy as you can, use barriers appropriately, and wash your hands often and well.

Hand-washing is the single most important thing you can do to prevent or control infection.**Hand-washing**

Every facility has hand-washing areas that are easy to find. Wash your hands with soap and lukewarm running water. Proper hand-washing is required to adequately cleanse the skin of contamination by potentially infectious microorganisms.

When soap and water are not available for washing your hands, apply an alcohol based antiseptic hand cleanser and rub your hands thoroughly until they are dry. As soon as possible, wash your hands with soap and water.

When to wash your hands

Almost any time is a good time to wash your hands at work. But at certain times we must all wash our hands:

- Before and after each shift worked
- Before and after every resident contact
- After using the bathroom
- Before and after handling food
- After handling anything you think is contaminated (dirty)
- After contact with blood or body fluids
- After smoking a cigarette
- After removing gloves
- After covering a cough or sneeze
- After blowing your nose

Wearing Gloves

Gloves should be worn anytime you may come in contact with contaminated objects or when feeding a resident who spits or drools.

Follow these simple steps when using gloves:

1. Wash your hands.
2. Slip gloves on, covering your entire hand and wrist.

Removing Gloves

Gloves should be removed immediately after you complete a task. How you remove gloves is very important because the outside surfaces may be contaminated. Remove them as described below if you are right-handed. Reverse your hands in each step if you are left-handed.

1. Using your right hand, grasp the glove on the left hand at the inside of the wrist with your thumb and finger. Take care to not touch your skin. Turn the glove inside out as you pull it down over your left hand.
2. Hold the used left glove in a ball in your gloved right hand.
3. Grasp the inside of the right glove at the inside of the wrist with your left hand, again being careful not to touch your skin.
4. Pull the right glove down over your right hand and over the used glove held in that hand. The right glove is now inside out with the left glove enclosed in it.
5. Dispose of the gloves in the trashcan. If the gloves are soiled with blood or other body fluids, follow your facility's infection control policies for disposal of contaminated waste.
6. Wash your hands.

Gowns and Plastic Aprons

Gowns and aprons are only worn when feeding a resident who often spills things or is unusually messy.

The Blood-borne Pathogen Standard

The Blood-borne Pathogen Standard requires all health care agencies, including long term care facilities, to provide training on infection control to their staff once a year. The purpose of this standard from the Occupational Safety and Health Administration (OSHA) is to help protect workers from disease.

Blood-borne pathogens are disease-causing microorganisms that are transmitted by blood or other body fluids. Body fluids include urine, feces (bowel movement), saliva (spit), semen, vomit, nasal secretions, and tears. All body fluids except sweat are considered potentially infectious. Diseases that are transmitted through contact with body fluids include AIDS, hepatitis B, and hepatitis C. Most people who have these diseases do not have any obvious signs. You cannot tell if people are infected just by looking at them, so it is important that you treat everyone the same way you would treat a person you knew to be infected. This means using Standard Precautions with all residents. Standard precautions mean using protective equipment such as gloves, gowns, and masks to prevent the spread of infection.

Standard Precautions

By using Standard Precautions you can reduce the risk of becoming infected and of infecting others.

- Hand-washing—wash your hands after contact with blood or other body fluids, after removing gloves, and between resident contacts.
- Gloves—use gloves whenever there is a chance that you will come in contact with blood or other body fluids
- Masks, eye protection, and face shields—use whenever there may be splashing or spraying of blood or other body fluids.
- Instructions for handling of resident equipment, linen, and needles, cleaning and disinfecting, and room placement of infected residents are also included.

Chapter 7

Resident's Rights

Chapter Seven Resident's Rights

Residents have Rights

In 1987, the nursing home reform law, commonly called **OBRA (Omnibus Budget Reconciliation Act, 1987)**, was passed. This law guarantees the rights of residents in long term care facilities. **Rights** are things to which a person is morally or legally entitled. The Residents' Bill of Rights contains many specific rights that pertain to all residents of long term care facilities. It is important to remember that residents are individuals who have the same rights as you. They have a right to be treated with respect and dignity, to pursue a meaningful life, and to be free from fear. They also have the same legal rights as all U.S. citizens. These rights include the right to vote and to not be discriminated against because of their age, sex, race, religion, ethnic group, sexual orientation, or disability. The facility and all staff must protect and promote each resident's rights.

What are the Resident's Rights?

The Resident's Bill of Rights gives the following rights to all residents:

The Right to Exercise One's Rights

All residents have the right to exercise the rights they have as residents of the facility and as citizens or residents of the United States. Residents have the right to be free of **interference, coercion, discrimination, and reprisal** from the facility when they exercise any of their rights. If a resident is judged incompetent under the laws of a state, the person appointed by the state to act on his or her behalf exercises those rights.

The Right to Privacy and Confidentiality

Residents have the right to confidentiality of their personal and medical records. You should not discuss a resident's personal or medical information with anyone except the nursing staff. Talk about residents with nursing staff only in private. Do not talk about a resident's personal information with other residents, a resident's relatives or friends, visitors, or your own friends. Only talk about residents with staff from other departments if you have been told it is okay to do so. If someone asks you a question about a resident, tell that person to talk with the nurse. The nurse knows who is allowed to have information about a resident.

The Relationship Between a Resident and the Feeding Assistant

As the residents get to know you, they may share personal information with you. It may be information about their family or about things that happened in the past. Do not share this information with others. The residents tell you these things because they trust you to keep them confidential.

Privacy Rights

Residents have the right to privacy in their rooms, in written and telephone communications, during medical treatment and personal care, and when meeting with visitors or family members. The residents' rooms are their homes. Always knock on the door and give them enough time to say, "Come in," before entering. Give residents time alone on the telephone or with visitors, especially spouses or significant others.

The Right to Information

Residents have the right to see their personal, medical, and financial records. If a resident asks you about the records, say you will ask the nurse to help them. Always take time to answer a resident's questions. If you are unsure of the answer, find someone who can help.

Right to Make Choices

Residents have the right to make choices about their living arrangements. Married residents have the right to share a room with their spouse, if both live in the facility and both consent. They also have the right to choose their personal physician, to help plan their care, and to refuse a treatment.

Make sure residents are aware of their choices. A resident's choices may have to be limited if they interfere with other residents' rights. Facilities have rules for the fair treatment of all residents.

Right to a Grievance

Each resident has the right to make complaints without fear of **retaliation** or discrimination. The facility must act promptly on complaints. Federal law requires each state to have an **ombudsman** program. The ombudsman investigates complaints from residents and family members and acts as their **advocate**. The facility must tell residents and their families about this program and how to contact the ombudsman.

If a resident complains to you, tell the charge nurse right away. Never ignore a resident's complaint. Do not let a complaint affect how you treat the resident. For example, if a resident complains that you have been rude, do not argue with them about what you said. Treat them with respect and make your best effort.

Right to be Free from Restraint and Abuse

Physical restraints, also called protective devices, may be used to permit appropriate medical treatment. For example, a confused resident's hands may be restrained to prevent them from pulling out tubes needed for feeding.

Some medications may sedate a resident or slow muscle activity. This reaction may be the purpose of the medication or may occur as a side effect. If one of these medications is used to keep a noisy resident quiet rather than for medical treatment, it is considered a chemical restraint. Each resident has the right to be free from any restraint used to discipline the resident or for the convenience of the staff.

Each resident has the right to be free from any verbal, sexual, physical, or mental abuse and from physical punishment or involuntary seclusion. Involuntary seclusion can mean being forced to stay in one's room alone, or to eat at a separate table in the dining room against one's wishes.

Examples of Abuse

- Intentionally injuring a resident
- Threatening to injure a resident
- Calling a resident a disrespectful name
- Yelling at a resident for spilling food
- Ignoring a resident while talking to another staff member

- Not answering a resident's call light
- Failure to give a resident appropriate care

Report any signs of abuse to the charge nurse. Not reporting abuse can make you just as responsible as the person who abused the resident. The law severely punishes anyone who abuses residents.

A feeding assistant who is found guilty of resident abuse will be fired and be reported to the state. The state must keep records of all reported incidents of abuse. Facilities are not allowed to hire or continue to employ anyone who has been found guilty of neglecting, abusing, or mistreating residents, or taking their property.

Chapter 8

Communication and Interpersonal Skills

Chapter Eight
Communication and Interpersonal Skills

Language is the light of the mind.

John Stuart Mill

What is Communication?

Communicate means to exchange information, ideas or messages in any way, as by talk, gestures, writing, etc. It also means to have a sympathetic or meaningful relationship and to be connected.

Communication is the passing of information from one person to another. If the information being sent is not clear, or the person receiving the information is not paying attention, there may not be accurate communication. The human species is hard-wired for communication. There is literally nothing we can do to NOT communicate. Why? Because communication is the fundamental means by which humans dominate the world we live in today.

By the age of four all normal children have acquired the rules of their native language with literally no formal instruction beyond day-to-day interaction. As a matter of fact, infants and toddlers in all cultures acquire language at the same rate, and no matter what the language, all of them make exactly the same grammatical mistakes. One goose -- two geese -- in Mandarin, Swahili and American Sign Language.

All humans communicate. We learn to communicate by osmosis, literally soaking up the environmental cues necessary to get our needs met. Our brains grow explosively, associating certain sounds, sights, actions and feelings with our experiences. This muscular contraction on my face gets me picked up. That particular scream gets me fed. And by the time we're four years old, we can string a comprehensive sentence together and express our wants and needs more directly. Some psychologists tell us that we have learned literally all we need to know about how to survive in our culture by the time we're four years old.

That's good news. But the bad news is those early experiences of learning through trial and error and association, harden into rules that, if we don't consciously think about, are never broken.

In other words, most adults communicate based on rules they acquired as toddlers, completely unaware of how profoundly they are communicating -- all the time. Everywhere. With everyone.

Look at people's faces. Notice how they walk, sit, stand and move. Eavesdrop. Listen to conversations. Watch people interact at work, in the grocery store, at the bank. Start paying attention. Communication is always and everywhere occurring. There is literally nothing we can do, short of dying or dropping into a coma, to NOT communicate.

Now consider how much of what you're observing about the communication in the world is absolutely unconscious, automatic and unintentional. Communication surrounds and pervades us, like water surrounds and pervades fish. And we don't even notice. An important skill to learn is how to communicate with residents. As some diseases progress, they lessen the resident's ability to communicate. Some residents are unable to communicate their needs directly. You will need to watch for signals that show their needs.

There are many different forms of communication. Some are very obvious:

- Speaking to someone
- Sending a letter
- Using sign language
- There are others of which we are less aware:
- Smiling
- Hugging
- Avoiding eye contact

Nonverbal Communication

Have you ever been able to tell that someone looks like they are unhappy or don't feel well without talking to them? That was because the person was providing information through nonverbal communication. This method of communication passes through actions of an individual's body. This form of communication can often be stronger than verbal communication. Non-verbal communication is often called **body language**. Unlike what we say, which is easy to control, nonverbal communication tends to give a more accurate view of how we **really feel** than is given by what we say. **Body language** includes:

- Posture
- Gestures
- Eye contact.
- Body movement
- Appearance
- Facial expression

Body Language

It is often possible to determine what a resident needs by watching body language. Holding the stomach may indicate a stomachache. Rubbing the upper arms is a sign of being cold.

Facial expressions can say a lot. Remember when a parent gave you "that look"? No one had to say anything; you knew you were in trouble. The residents also communicate with their facial expression. For example, if a resident makes a face when being fed, this may mean that the food does not taste good.

The Feeding Assistant's Body Language

It is important to remember that the residents will receive your nonverbal communication. If a resident spills tea, don't roll your eyes or make a face. Try to send positive messages to the resident. Smile often. It will help both you and the residents to feel better.

Using Touch to Communicate

Touch is a meaningful form of communication for some residents. Physical cuing communicates your wishes to the resident. Holding a hand or giving a hug shows that you care. However, some residents do not want to be touched. This may be for religious, cultural, or personal reasons. Ask the resident, "Would you like a hug?" or "May I hold your hand?"

Tone of Voice

Tone of voice often communicates more than words. Your gentle, patient tone tells residents they can feel safe with you and trust you. The resident's tone also helps you understand their needs even when their words do not make sense. Is it angry or pleasant? Does it indicate frustration?

Effective Speaking

- Face the resident as you speak. Older residents may have decreased hearing and need to rely on facial expression and gestures.
- Maintain eye contact with the resident. Avoid looking around the room while you are speaking with the resident.
- Be aware of the resident's personal space. Everyone has an invisible box that is personal space. We get uncomfortable when someone comes into our space. If a resident moves back or appears uneasy when you approach, you may need to step back a little.
- Do not talk with other staff members and ignore the resident. A coworker may have something interesting to tell you but it can wait until later. Most residents value the time you spend with them.
- Words do not always mean the same thing to each person. Use simple language.
- Don't use medical terms when talking with a resident. The resident probably does not know what terms like "dysphagia" mean. Don't use slang or "in words" that the resident may not understand.
- Speak clearly. Don't talk while chewing gum or with your hands in front of your face.
- Don't give more information than the resident needs. This can be confusing.
- Give the resident time to answer questions. Elderly residents often need a little extra time to respond.

There is a tendency to shout at residents who have visual or hearing impairments. Speak clearly and loudly enough for the resident to hear, but do not shout. Ask questions that can be answered with "yes" or "no" or a nod if the resident has difficulty speaking.

Being a Good Listener: 5 "Musts" to good listening

According to Webster, "to intend" means to stretch out for, to aim at. Intent is a purpose, object or aim.

It struck me like a thunderbolt to discover that the root of the word "listen" comes from Middle English, and means, "to merge." But the modern definition, according to Webster, is "to make a conscious effort to hear; to attend closely."

Again, our friend Webster: "Conscious" means: "having a feeling or knowledge of one's own sensations, feelings, etc., or of external things; knowing or feeling; aware; cognizant. 2) able to feel and think in the normal waking state; 3) aware of oneself as a thinking being; knowing what one is doing and why.

When we look at the definition of "to hear," we find "to perceive or sense sounds, especially through stimulation of auditory nerves in the ear by sound waves."

So, intentional listening: Being aware of myself as a thinking being, aiming myself at "merging" by perceiving or sensing what another is saying.

I don't know about you, but given the brief exploration in the dictionary, I don't see a whole lot of intentional listening in the world.

What if you could create that experience of connection, of merging with anyone? Any time? Under any circumstances? I have no idea if that is even possible, but I live life each day aiming myself at that possibility. And here's what I find out:

Stuff just gets in the way of listening. What stuff? Mostly being aware of my own internal sensations, rather than being aware of or having feelings for external things --like the other person.

Yeah, the sound waves stimulate my auditory nerves, resulting in something called "hearing," but listening? It's the most difficult thing a human can do.

My friends, we as a species are in very deep weeds when it comes to listening. Each of us is a "closed loop," consisting of our own unique history, experience, vocabulary and coding/decoding system.

But -- keep the faith. There are footprints out there in the wilderness, and I am committed not only to following them, but to taking you with me. Here's what every listener needs to know in order to merge -- to have that awareness or feeling for external things (the other person), to create that sympathetic and meaningful relationship. Consider these five "musts" as the handrails that keep you on track as you learn to listen intentionally.

1. Listen with a purpose.

What purpose, you ask? Well, how about adopting the purpose of connecting with the other person -- really finding out about their reality. I guarantee this is not always easy, nor is it always the first idea of purpose that pops into your head. Here's a little practice exercise to play with.

In your very next conversation, I'd like you to become aware of your internal monologue. Interrupt it, and ask yourself: "What's my purpose in listening right now?" Listen to what your internal voice says back. Don't be dismayed if the internal voice has some other, less than noble, purpose like: "My purpose right now is to get them to hurry up and stop talking," or "Right now, all I want is out of this conversation," or "My only purpose in listening is so that I can show them how wrong they are when it's my turn."

Hey -- it's called the human condition. Forgive yourself, laugh at yourself, and just pretend that you want to connect in a meaningful way with the other person. I promise that if you pretend long enough it becomes a habit, and the outcomes of this habit sure beat the alternative.

2. Practice listening for understanding, rather than evaluation

We are all hopelessly hard-wired to evaluate. As creatures, we are subject to the same rules and conditions as all creatures -- and one of those rules is to evaluate the world in terms of its capacity to threaten our survival right now.

Unfortunately, that hard-wiring has an inherent flaw. Most modern people like you and me are rarely faced with survival-threatening events. Yet, when somebody engaged in conversation with us expresses frustration, fear, anger, or merely a different opinion than we hold, we react as if a stampede of saber-toothed tigers is busy sharpening their claws in our direction.

The fact is that every opinion anybody has is a learned one. That other person has a history, and very good reasons for their thoughts, opinions, beliefs, word choices, and behaviors, just like you do.

Communication, contrary to the present world view, is not meant to be combat. Our job is to practice just imagining what the other person's world view must be, rather than trying to change it, fight it, or argue them out of it.

The key word in this "must," though, is practice. Repeated behavior over time. Letting other people be, and opening yourself up to imagine other points of view than your own, is the hardest practice you'll ever do.

3. Be aware of words, phrases, and behaviors that distract and make you defensive; and exercise emotional control even though you disagree.

The fastest way to become aware of those words, phrases and behaviors is to keep an "upset log" in which you jot down each and every "hot button" that you have as it gets pushed. Maybe it's being called stupid, or perhaps it's that adolescent eye-rolling behavior that gets to you. How about certain curse words?

How much energy have you spent trying to get all those other people to stop pushing your buttons? That is the worst possible investment of your energy. Look at your record. Your own history should show you that the odds are very much against you.

Instead, invest your energy in reconfiguring your wiring so that you can exercise emotional control. Practice. Use the "Perspective Game." So that 13-year-old rolls her eyes, heaves a great sigh, and says in a monotone, "I don't know." Feel the adrenaline rush, just notice it, and before any words leave your mouth, get some perspective by asking yourself a question like, "How is this situation the same as getting both my legs cut off in a freak train accident?"

4. Concentrate on what they are saying, in spite of distractions

Let's face it -- the deck is woefully stacked against us when it comes to true listening. Not only are we plagued by the endless internal monologue -- we also have to contend with external distractions in our environment. Time, to-do lists, noisy equipment or crowded rooms can all get in the way of listening.

The best way to concentrate in spite of distractions may be to deal with them first, so that you offer the other person the courtesy of your undivided attention. Do that by telling the person the truth: "I'm distracted right now because I have a meeting in five minutes. Can we talk in an hour, when I can give you my full attention?" Or, "It's hard for me to concentrate on you while that loud music is playing. Let's turn it down so I can listen better."

5. Recognize that listening powerfully may be the key to success in anything you do

Whether your success is defined as moving up in your organization, making more money, having loads of friends, or minimizing stress and maximizing your health, poor listening can be the missing piece that keeps you from experiencing that success.

Intentional listening builds relationships. In your work, look at how much of your job depends on getting cooperation from other people. Whether you're the top dog or the underdog, you can't do it alone. The person you're dealing with may be a bona-fide, certifiable jerk, but treating them that way will not get you much in the way of cooperation from them. I guarantee that listening will.

Reconfiguring your own wiring so that nobody gets you upset without your conscious cooperation has a liberating effect on your sense of control. When you feel more in charge of yourself, you experience less stress -- and the toll that stress takes on your body is minimized. You feel more content, complete and satisfied.

When you feel content, complete and satisfied with yourself, you are a joy for others to be around. Your circle of friends expands. Your family welcomes you home, and life is good.

Remember the last paragraph above. Residents of nursing homes deserve the same feelings. Many residents are lonely and need someone to talk to. They enjoy talking about their families and things they used to do. It is important to respect the resident and listen to what they have to say.

Sit down whenever possible. This shows that you are ready to listen.

- Concentrate on what the resident is saying.
- Show that you are interested: maintain eye contact, smile or nod to indicate that you understand.
- Make comments that show interest.
- Remember that the resident will read your body language.
- Don't interrupt. Let the resident finish talking before you start.
- Don't finish sentences for the resident or "jump to conclusions." Sometimes a resident has to stop for a minute to think of what to say.
- Don't criticize what the resident says. Everyone has a right to his or her own opinion.
- If you are not sure what the resident means, clarify by saying, "Do you mean that..." or "This is what I think you are saying..."
- Allow the resident to complain about the food. A person might say, "The orange juice is sour." A small complaint or comment about the food is natural and normal.

Knowing When to be Silent

- There may be times when a resident doesn't want to have a conversation during a meal.
- The resident may not be feeling well.
- The resident may be tired.
- The resident may be angry.
- The resident may be depressed.
- The resident just doesn't feel like talking.

If you think the resident is not feeling well or is depressed, report it to the charge nurse. It is important that you respect the resident's wishes. Although friendly mealtime conversation is good most of the time, it is not always necessary. Also, you should adapt your communication style to match the resident's. With some people, you will talk more than with others.

Not wanting to talk may not mean that the resident wants to be left alone. Ask the resident if they would like you to stay. Sometimes just being there communicates caring better than words.

Things that should not be said

As you get to know the residents, you may have long conversations with them. They may enjoy hearing about your family or your vacation. However, there are also certain things that you should not talk about with a resident, such as:

Any information about another resident

Things that happen with the staff such as someone being disciplined

Any negative thoughts or feelings you have about residents or staff

Unhappiness with your job or the facility

Communication with the residents during a meal should be pleasant and positive. Encourage them to talk about themselves and what they like to do.

Communicating with Residents who have Dementia

Your facial expression affects your communication with a resident who has Alzheimer's disease. As the disease progresses, you need to change how you communicate with the resident. Watch the resident for cues. Adapt your communication to make positive experiences for the resident. In the middle stage of illness, residents can communicate fairly well and generally understand simple, one-step instructions. They commonly have problems finding the right word, especially the names of things. They may use the wrong words, ramble, or talk around the point. They may also stutter mildly.

As the disease progresses, residents have problems forming full sentences and understanding simple sentences. They may stop speaking except when spoken to. They have more trouble finding the right word. They may speak in only a few words, and they have difficulty staying on the topic. Residents who speak English as a second language will return to their first language. In the late, severe stage of illness, residents lose all but the most basic verbal skills. They cannot comprehend much. They communicate mainly through body language. They may also moan or scream.

Depending on the disease progression and the resident's reactions, choose the best communication techniques.

Suggested Communication Techniques for Residents with Dementia

Speak slowly and clearly, using simple one-step commands.

Give the resident time to respond.

Limit choices you offer these residents to two things, stating each choice simply. Give them time to respond to the first choice before offering the second. If the resident cannot make choices, do not give them choices.

With late-stage residents, use only the simplest words and communicate through gentle, pleasant tones of voice, facial expressions, and gentle touch.

Do not treat the residents like children. Remember they are adults and their feelings are still intact.

Validation

Residents who are cognitively impaired may not have an accurate picture of reality. As the disease progresses, residents often go back to earlier times in their lives. This is their reality. You cannot bring them to the present. Attempting to do so will only upset them. You must meet them in their reality. By asking questions, you can often redirect the resident away from unwanted behaviors and troubling thoughts. Remember to ask questions in the present tense; use words like “is” and “are” instead of “was” and “were”.

Suggestions for Responding to Residents

Validate a resident’s perception of reality whenever possible.

For example:

Mrs. Anderson is headed for the door. She tells you that she has to go home. She is late and her mother will be upset. Mrs. Anderson is 87 years old. You know that her mother is dead. If you tell her this, she will most likely begin to cry. Instead, ask Mrs. Anderson to tell you about her mother:

What color is your mother’s hair?

What do you like to do with your mother?

Do you like to bake cookies?

I have some cookies. Would you like to have cookies and milk?

Try to distract a resident from troubling thoughts.

Mr. Best seems very upset. He tells you that he doesn’t remember how to get to school. Ask Mr. Best about school. What is your favorite class? Do you like art class? Would you like to help me make a poster? If Mr. Best gets involved in an activity, he will probably forget about the school.

Do not try to force a resident to do something that upsets them.

Mrs. Abbott does not want to go to the dining room. She is sitting in the hall and refuses to move. Ask Mrs. Abbott if she would like a graham cracker. If so, bring one to her. After a few minutes, tell her that you have some milk that would go good with the cracker. Would she like to come and get some? If she refuses, do not try to force her. Try again later, or have someone else try. A resident may respond to one person better than another.

Ask simple questions the resident can answer with a “yes” or “no.”

You are going to feed Mr. Bartell and you want to give him choices. Instead of saying, “What do you want first?” ask, “Would you like to start with the roast beef?”

When giving directions, give one step at a time and include nonverbal cues whenever you can.

Mrs. Foster seems lonely so you ask her to help you fold the napkins. Give the following instructions, allowing time to complete one before going on to the next:

Place the napkin on the table. Smooth it out.

Fold it in half (make a folding motion with your hands) Say, That’s right

Fold it again (repeat folding motion) Okay

Put it over here (indicate place with your hand) Thank you

As a resident's communication skills decline, send nonverbal cues using their different senses. While assisting a resident with lunch you notice that Mr. Mason is not eating. Point to the bread and tell him to pick it up. Say, "See how good the bread smells" while raising your hand to your nose. Say, "Try a bite" and point to your mouth. Rub your stomach and say, "Doesn't that taste good?"

Speaking with Residents who have Hearing Impairments.

1. Get the residents attention gently.
 - Make sure the resident sees you.
 - Touch them gently to indicate you want to speak to them.
 - Remember that residents hear even more poorly when they are ill or tired.
2. If the resident wears a hearing aid, be sure it is in the ear and it is on.
3. If the resident has a "good" ear, stand on that side to speak to them.
4. Never chew gum, eat, or cover your mouth while speaking to them.
5. Make sure any lighting is behind the resident and on you so they may see your face. This is because many hearing impaired individuals can read lips to understand what you are saying. Your face also tells them a great many things. Review non-verbal communication.
6. Speak quietly, slowly, calmly, distinctly and as naturally as possible.
7. The hearing impaired often depends on context to understand what you're saying. So don't change subjects until you know they understood you. It is always a good idea to have a note pad handy to write what you want to say. (As long as they can see the note to read it)

Remember that some hearing-impaired people may be embarrassed that they can't hear well. Be sensitive to that possibility. They may seem confused if they are having difficulty understanding you.

Lastly, never walk away from a resident, hearing, hearing impaired, deaf, or not, leaving them wondering what you said. This leaves a strong impression that you don't care.

Communicating with residents with Aphasia.

Aphasia means that the resident cannot understand spoken or written language or cannot express spoken or written language. One is called receptive aphasia and the latter is termed expressive aphasia. Either one can be very frustrating to the resident or to yourself if you don't realize what's going on with the resident.

Always face the resident, making eye contact with them. Greet them using their name. Everyone likes to be called by their name. Speak slowly and clearly using short sentences and pause between sentences to allow the resident time to comprehend and interpret what you said. Check their understanding before you continue. Remember non-verbal communication. You will say more to them that way than you will verbally. And they will understand it better.

Ask simple questions that can be answered with one or two words or by a headshake or some other gesture. Check with the nurse to see if there are alternative communicating devices such as signboards or picture boards. Don't shout or raise your voice or talk "baby" talk to get them to understand.

Communication and Interpersonal Skills

10

If you sense frustration in the resident, just acknowledge it to them and suggest you talk about something they want to discuss. But never ignore someone with aphasia. It's rude and uncaring and only increases their frustration because they cannot communicate well.

Communicating with residents of different cultures.

If you get assigned to someone from a different ethnic and cultural background, be sure you get specific guidelines on how to communicate. For example: In some countries it is disrespectful to maintain eye contact when speaking to someone. Some cultures resent being touched unless you are a family member. So understand the residents you work with to make their life more pleasant and provide them with a high quality of personal caring.

Chapter 9

Food-borne Illness

Chapter Nine Food-borne Illness

There are three (3) reasons food becomes unsafe to eat; time and temperature, cross contamination, and personal hygiene.

There are 6 things microorganisms need to grow. They can be remembered by the acronym FAT TOM. They need nutrients (**F**ood), **A**cidity (pH 4.6 to 7.5), **T**emperature (41 to 140 degrees or 5 to 60 degrees C.), **T**ime (If left in the temperature danger zone for 4 hours or more, pathogens can grow fast enough and in quantities to make people sick), **O**xygen and **M**oisture.

Food-borne Illnesses

Food-borne illness is a disease carried or transmitted to people by food. The CDC defines a food-borne illness outbreak as an incident in which two or more people experience the same illness after eating the same food.

The elderly are at high risk of contracting a food-borne illness because their immune systems and resistance may have weakened with age.

Major Food-borne Illnesses

The following are only some of the food-borne illnesses: Salmonellosis, Shigellosis, Listeriosis, Gastroenteritis, and Botulism.

Major Causes of Food-borne Illnesses

Time and Temperature Abuse

This means food has been left too long at temperatures where bacteria and viruses can grow abundantly. Some common situations that perpetuate food-borne illness are:

- Failure to keep foods at the proper temperatures.
- Failure to cook foods to the proper temperature.
- Failure to cool foods properly.
- Failure to serve food promptly after cooking.

There is what is known as the *temperature danger zone* (41° to 141 °F.) Holding food must be held at the proper temperatures. Hold hot food at 140° or higher. Hold cold food at 41° F. Therefore, as you do the dining or kitchen observations it is necessary to check temperatures on food tables maintaining hot or cold foods for serving.

Cross Contamination

This occurs when foods touch other foods or surfaces picking up microorganisms as they touch. Some examples of cross contamination include:

- Food contacting surfaces that are not properly cleaned and sanitized.
- When uncooked foods drip fluids on already cooked food.
- Food preparation personnel handling raw foods then cooked foods without properly washing hands.
- Clothing or cleaning cloths touching foods.

Poor Personal Hygiene

- Anyone working in the kitchen preparing food and/or serving food must have good personal hygiene and wear appropriate protective gear such as hair nets.
- Employees who don't wash hands regularly.
- Employees coughing or sneezing over food.
- Employees who scratch or touch exposed areas of the body then touch food.

Chapter 10

Safety and Emergency Procedures

Chapter Ten Safety and Emergency Procedures

An emergency is defined as any situation that requires immediate attention and usually medical intervention. Emergency situations come on quickly and are almost always unpredictable. They can happen to anyone at anytime. Consider your own life; maybe you've been in an emergency situation such as an automobile accident or a fall that required some else to help you get up or take you to a medical facility.

In nursing homes accidents happen, as do emergency situations. As a feeding assistant it is imperative you are familiar with some specific emergency situations such as choking, cardiac and respiratory arrest. The regulations governing feeding assistants do not require you to be trained in cardio-pulmonary resuscitation (CPR). Depending on facility policy and procedures you may be required to be trained in this area. If so, you will be expected to respond appropriately. Training in this area will not be covered here.

General Guidelines in Emergency Situations

The ABC's of any emergency are pertinent to the feeding assistant duties. These ABC's are:

A = airway

B = breathing

C = circulation

Emergency situations often cause a variety of emotions, which too often result in confusion and possibly chaos. All persons working in health care must be able to recognize emergency situations and respond appropriately to intervene and prevent further insult or injury to a resident. Some key points are:

- Remain calm. Nothing can be accomplished when you and those around you become flustered and agitated at the situation. Remaining calm can be a calming influence to the resident and others around you.
- Know the procedures for summoning help in your facility. The licensed nurse in the facility will be the first responder in most facility emergency situations. In general, calling out for help will be the procedure you follow. It is imperative you stay with the resident to support them, and if you are trained to intervene in the emergency, you are expected follow through with it.
- Never move the resident unless they are in greater danger staying there.
- Stay with the resident until released by the person in charge.
- Know your limitations. Never do anything for which you are not trained and competent to perform.
- Know the procedures for initiating the emergency response system in your facility and the emergency medical system. Facilities have a variety of code names for different situations. Know them and what your responsibilities are in each situation.

While you are working in a long term care facility you will always be close to medical help. The main point is to ensure the resident is not endangered further.

Choking

Choking is the most common emergency situation you are likely to experience. Cardiac and respiratory arrests are the other emergency situations that may occur. Depending on facility policy and procedure, you may be required to learn the interventions in these situations. However, for our purpose, choking and the Heimlich Maneuver will be covered here. Your instructor will provide the practical experience before you will actually perform your duties as a feeding assistant.

Choking occurs when some object blocks the airway and air cannot pass the object, causing breathing to stop. This requires quick and decisive action. The airway can be blocked by any object or material large enough to block the airway. As a feeding assistant it is imperative you be knowledgeable about choking, its causes and interventions. Review the feeding technique section to ensure you follow those guides and any other your instructor may provide. For this section make sure food is the proper consistency and cut (if necessary) to small bite sizes to avoid the possibility of choking.

However, even this may not avoid a choking episode. Residents may not fully swallow their food, causing food to accumulate in the back of their throat. Enough of this accumulation can cause the airway to be blocked and the resident to choke. As the person feeding, you must be aware of any changes in the resident's situation. As food accumulates you may hear slight changes in the resident's breath sounds that may indicate a need to intervene to prevent a choking incident.

Interventions

There are several techniques to intervene. However, before taking any action, if the resident is coughing repeatedly and can speak don't intervene. Stay with the resident and provide any physical support if required and encourage them. Coughing is the best way to dislodge anything in the throat obstructing the airway.

The classic signs of choking are: the person is unable to speak, high-pitched sounds may be present on inhalation, and the universal sign of choking is the hand(s) to the throat. Tilting the head back can sometimes help clear the airway as this movement causes the tongue to be pulled forward and can dislodge the object or accumulated food in the throat.



The Heimlich Maneuver – Abdominal Thrusts

Every year about 3,000 adults die because they accidentally inhale rather than swallow food. The food gets stuck and blocks their trachea, making breathing impossible. Death follows rapidly unless the food or other foreign material can be displaced from the airway. This condition is so common it has been nicknamed the "cafe coronary."

In 1974, Dr. Henry Heimlich first described an emergency technique for expelling foreign material blocking the trachea. This technique, now called the Heimlich maneuver or abdominal thrusts, is simple enough that it can be performed immediately by anyone trained in the maneuver. The Heimlich maneuver is a standard part of all first aid courses.

The theory behind the Heimlich maneuver is that by compressing the abdomen below the level of the diaphragm, air is forced under pressure out of the lungs dislodging the obstruction in the trachea and bringing the foreign material back up into the mouth.

Procedures for the Heimlich

1. Always ask the person if they are choking. While this seems like a ludicrous question and a waste of time in this situation, if the person responds yes, then they don't need immediate intervention because they are obviously able to exchange air. Just encourage them to cough.

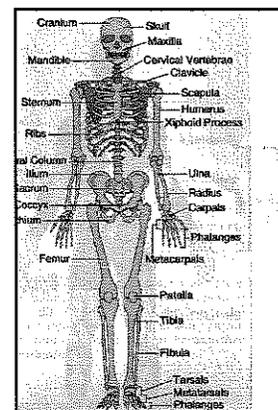
2. If they aren't able to respond and can't cough or breathe, and are still conscious, begin the Heimlich maneuver or abdominal thrusts as it is also called. The quick compression of the diaphragm forces air out of the lungs expelling the blockage.

a. Position yourself behind the individual and wrap your arms around the person. Make a fist with one hand and keep that thumb straight placed along side the middle knuckle of the first hand.

b. Place the fist with the thumb against the resident's abdomen between the navel and the bottom of the xiphoid process. (The xiphoid process is the bone that protrudes at the middle of the rib cage [middle of the chest]. Be sure you are not pressing on that bone as it could be broken and puncture an internal organ causing much more damage).

c. Cover the fist with your other hand, being careful not to press on the rib cage with your arms. This could cause damage to internal organs like the liver.

d. Now thrust forcibly with both hands at the midline of the resident's abdomen inward and upward. Keep your elbows bent and out away from your body. If the object is not dislodged the second time, repeat the procedure and activate the EMS system in the facility. Continue until it is expelled or the resident goes unconscious. If the resident goes unconscious you must proceed with the next step of assisting a resident with an obstructed airway. Be sure facility policy allows you to perform these duties. By this time there will be plenty of facility staff to help.



The Resident Who Goes Unconscious

If the victim goes unconscious, you should lay the resident on the floor, grasping the chin and being sure the tongue is not blocking the airway. With your index finger of the other hand, go along the inside of one cheek and with a hooking motion feel in the mouth for foreign objects, being careful not to push any farther into the airway. If successful the resident will begin to breathe on her or his own.

If unsuccessful, kneel astride the resident's thighs and place your hands, one on top of the other, between the bottom of the victim's breastbone and the navel. Then execute a series of 6-10 sharp compressions by pushing inward and upward. The pressure should force air from the lungs and force out the obstruction.

If unsuccessful, continue the abdominal thrusts, and repeat the process of lifting the chin, moving the tongue, feeling for and possibly removing the foreign material. If the airway is not clear, repeat the abdominal thrusts as often as necessary. If the foreign object has been removed, but the victim is not breathing, the rescuer starts CPR.

Appendix A

Terminology

**Appendix A
Terminology**

Abuse—maltreatment of another person, including physically, psychologically, or financially, or neglecting someone for whom you are responsible

Activities of daily living (ADL) — daily self-care tasks such as eating, dressing, toileting.

Advocate —someone who stands up for the rights of another person.

Airway obstruction —blockage of the windpipe

Allergy —a reaction to substances in foods or in the environment

Alzheimer's disease —a progressive, irreversible brain disorder which leads to a gradual memory loss, inability to perform routine tasks, disorientation, and loss of communication skills.

Aphasia —a problem with speech and understanding language

Appetite —a desire for something, often food.

Aspirate —to breathe fluid or a foreign body into the lungs

Aspiration —swallowing food or fluid into the windpipe

Assistive device —equipment that allows a resident to function independently; also called adaptive equipment

Blood-borne Pathogen — a disease-causing microorganism that is transmitted by eating infected food.

Body language —posture, gestures, eye contact, body movement, appearance, or facial expression that passes information from one person to another

Calorie —a unit of measurement for the energy value of food.

Cardiac arrest —the heart stops beating and blood does not circulate.

Cardiopulmonary resuscitation (CPR) —the procedure done to maintain breathing and circulation for a person in cardiac arrest

Charge nurse —the nurse who is responsible for a specific area of a facility

Chemical restraint —a drug that restricts someone's movement or behavior by making them calm or sleepy

Chronic illness —an ongoing illness such as arthritis, diabetes, or asthma

CNA — certified nurse assistant; an individual who has completed a training course in basic nursing care for the elderly and passed the state certification examination

Code —a signal or password that you use in an emergency: Code Red usually means fire; Code Blue means cardiac arrest

Coercion —pressuring someone to do something

Cognitive impairment —a temporary or permanent change in thinking; problems with memory, awareness, or judgment, abnormal thinking and reasoning caused by damage to the brain; dementia

Communication —passing information from one person to another

Confidentiality —keeping information private; not sharing information with others

Contaminated —soiled, dirty, containing pathogens

Coronary —involving the heart; a heart attack.

Cuing —giving verbal suggestions (pick up the spoon); or physical suggestions (a gentle nudge); prompting

Decubitus ulcer —skin breakdown that occurs when circulation is cut off; a pressure sore

Dehydration — a serious condition that can occur if a resident does not have adequate fluid intake

Dementia —loss of mental function such as memory, thinking, and reasoning, caused by changes in the brain.

Diabetes Type I —a disorder caused by the failure of the pancreas to release enough insulin in the body; a person with this disorder receives insulin shots.

Diabetes Type II —a disorder caused by the inability of the cells to absorb glucose (sugar) in the bloodstream.

Diet card —a card with the resident's name, type of diet, feeding instructions,

Discrimination —making distinctions between individuals when providing services, treatment or employment.

Dysphagia —difficulty swallowing

Edema —retaining fluid in the body

Emergency Medical Service (EMS) — individuals with special training in responding to medical emergencies.

Facial expression —appearance of one's face such as a smile, frown, lifting one's eyebrows, a wink

Faint —to lose consciousness.

Feeding tube —a tube that is inserted into the stomach, through which a liquid diet is administered.

First aid —immediate treatment given to a person in an emergency

Flow sheet —a document used to record observations made on a regular basis such as fluid intake or blood pressure.

Food-borne illness —food poisoning.

Heimlich maneuver — an emergency technique for dislodging food or an object from the windpipe of a choking person

Hydration —maintaining adequate fluid in the body; the taking in of fluids

Hypertension—high blood pressure; blood pressure that stays above the normal healthy range

Infection—a disease caused by a microorganism, such as a cold, flu, and pneumonia.

Interference—acting in a manner that disrupts an action.

Involuntary seclusion—being forced to be alone or separated from other people in the facility

IV feeding —intravenous feeding; providing nourishment through a needle that is inserted in a vein

Kosher—food prepared according to the dietary laws of Judaism

Lactose intolerant—A person who cannot digest the sugar (lactose) found in milk and milk products

LPN — licensed practical nurse; an individual who has completed a one year training program in nursing care and passed the state LPN licensing examination.

Malnutrition—a lack of proper nutrition because of an unbalanced diet, which can be eating too much food or too little food or the wrong kinds of foods

Metabolism—the chemical processes that take place in the body that relate to the movement of nutrients in the blood after digestion, that result in all body functions

Microorganism—any small living plant or animal that can only be seen with a microscope.

Misinterpret—forming the wrong idea about a situation or instruction

Multi-infarct dementia— a series of small strokes, which cause a gradual loss of cognitive function

Myocardial infarction (MI) —a heart attack

Nonverbal communication—passing information without speaking, through facial expression or body language

NPO—nothing by mouth; the resident may not have anything to eat or drink.

Nutrient dense—food that is high in nutrition but low in calories

Nutrition—the process of taking in and using food elements for body functioning and aids in growth and development of the body

OBRA—Omnibus Budget Reconciliation Act of 1987, regulations published by the federal government

Occupational Safety and Health Administration (OSHA) -- the federal agency that is concerned with the health and safety of workers

Occupational therapist—a therapist who helps residents learn to do tasks of daily living

Ombudsman—a person who serves as an advocate when a resident or family member believes the resident's rights have been violated

Over bed table—a table with wheels that can be adjusted to fit over the bed

Palpitations —are strong, rapid heartbeats

Parkinson's disease—a progressive disorder of the central nervous system, which leads to a loss of muscle control

Pathogen—a microorganism that causes an infection; a germ

Physical restraints—items used to restrict someone's physical movement; also called protective devices

Reprisal—getting back at someone

Respiratory—breathing

Retaliation—returning an unkind word, or action in a similar way; tit-for-tat

Rights—things to which a resident is morally or legally entitled

RN —registered nurse; an individual who has completed a two to four year training program in all aspects of nursing care and passed the state RN licensing examination

Scald—a burn caused by contact with a hot liquid

Sedate—to make sleepy or calm

Seizure —repeated involuntary muscle movements caused by abnormal electrical activity in the brain

Sodium —an element needed for water balance in the body, which can be supplied by table salt

Standard Precautions—use of protective equipment (gloves, gowns, masks) to prevent the spread of infection by blood or other body fluids

Subjective information—information based on your opinion or your idea about a situation.

Supplements—a food meant to provide concentrated nutrition to a person who cannot eat enough food to supply the calories and protein they need

Syncope—a fainting spell caused by one of many causes

Therapeutic diet —special diet that is a treatment for a disease or condition

Transmit—to send something from one place to another place or from one person to another

Tremor—quivering movements, or shaking, especially in the hands

Validate—a process of asking questions to show acceptance to a resident's ideas

Vegetarian—a person who does not eat meat or poultry; some vegetarians do not eat fish, eggs, or dairy products

Appendix B

Instructing the Mature Learner

Appendix B Instructing The Mature Learner

The following is a brief overview for the benefit of the instructor. The feeding assistant training program will attract a variety of individuals in various stages of their life. It is important to have at least a basic understanding of training and the characteristics of those you are training.

Initial Impressions

- a. **Credibility:** Be confident in your own ability to teach and in your nursing skills.
- b. **Professionalism:** Be approachable, flexible, and willing to admit when you do not know the answer to a question. Your appearance, language, positive attitude, and mannerisms will send a message to the students that will translate into how they perform their duties of the feeding assistant. Be enthusiastic about what you're teaching and they will be enthusiastic about doing their job.
- c. **Set Standards:** Be clear on the expected outcomes of the class and how they are to perform their duties. Establish criteria for the pass/fail rate and stick to it.
- d. **Be Consistent and Fair:** Establish expected behavior and treat all students by the same standard. Give praise and encouragement as needed. Correct as needed without humiliation or embarrassment to the student.
- e. **Learning Environment:** Be aware of the environment in which you are training these students. Be prepared and have all needed training tools and materials available. Make the training area comfortable, well lighted, with easy access to bathroom facilities, and without noises and interruptions.

It is important to understand the students in your class. Compassion and empathy are an important part of being an instructor. Express concerns for their welfare and success in the program, but don't get involved in their issues. Always have outside resources available to assist those students who need help.

The Experienced Worker

The experienced worker may be some of your own facility employees. The federal requirements apply to them also. Housekeepers, laundry workers, social workers, maintenance and maybe business office workers all must attend and pass this training. This may provide some unique challenges.

Any employee other than licensed nurses and nursing assistants must be trained. The employee may have worked in the facility for years, but still must be competent as required by federal regulation to feed residents. Don't let them snow you into believing they don't need the training. Surveyors will check training records to assure those who are not nurses or nursing assistants are properly trained and passed the course.

Appendix C

Final Rule

(Modified)

Appendix C

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

42 CFR Parts 483 and 488

[CMS-2131-F]

RIN 0938-AL04

Medicare and Medicaid Programs; Requirements for Paid Feeding Assistants in Long Term Care Facilities

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule permits a long term care facility to use paid feeding assistants to supplement the services of certified nurse aides under certain conditions. States must approve training programs for feeding assistants using Federal requirements as minimum standards. Feeding assistants must successfully complete a State-approved training program and work under the supervision of a registered nurse or licensed practical nurse. The intent is to provide more residents with help in eating and drinking and reduce the incidence of unplanned weight loss and dehydration.

EFFECTIVE DATE: These regulations are effective on October 27, 2003.

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SUPPLEMENTARY INFORMATION:

Copies:

This Federal Register document is also available from the Federal Register online database through GPO access, a service of the U.S. Government Printing Office. The Web site address is <http://www.access.gpo.gov/nara/index.html>.

I. Background

Legislation

Sections 1819(a) through (e) and 1919(a) through (e) of the Social Security Act (the Act) set forth the requirements that long term care facilities must meet to participate in the Medicare and Medicaid programs, respectively. Sections 1819(f)(2) and 1919(f)(2) of the Act contain requirements for nurse aide training and competency evaluation programs (NATCEP). Sections 1819(g) and 1919(g) of the Act contain the criteria that we use to assess a facility's compliance

HFAM QIC, October, 2003
Revised March, 2004

with the requirements. These statutory provisions were mandated by the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) (Pub. L. 100-203, enacted December 22, 1987). The requirements for long term care facilities are codified at 42 CFR part 483, subpart B; the nurse aide training and competency evaluation program requirements are codified at 42 CFR part 483, subpart D; and the survey, certification and enforcement procedures are codified at 42 CFR part 488, subparts E and F.

Sections 1819(b)(5)(F) and 1919(b)(5)(F) of the Act and regulations at § 483.75(e) define a nurse aide as any individual furnishing nursing or nursing-related services to residents in a facility, who is not a licensed health professional, a registered dietitian, or someone who volunteers to provide services without pay. Sections 1819(f)(2) and 1919(f)(2) of the Act set forth the requirements for approval of a nurse aide training and competency evaluation program, but do not define "nursing" or "nursing related" skills.

Section 483.152 of the regulations specifies nurse aide training requirements. These include, for example, basic nursing skills, personal care skills, communication and interpersonal skills, infection control, safety and emergency procedures, mental health and social service needs, residents' rights, care of cognitively impaired residents, and basic restorative services.

On March 29, 2002, we published in the Federal Register a proposed rule, "Requirements for Paid Feeding Assistants in Long Term Care Facilities" (67 FR 15149), that offered long-term care facilities the option to use paid feeding assistants, if consistent with State law. Current Program Experience Currently, there is no provision in the regulations for the use of single-task workers, such as paid feeding assistants, in nursing homes. To ensure the safety workers in long-term care: Research challenges and opportunities.

Generations, 25(1), 49-57.

2 Stone, R.I., with Weiner, J. A. (2001). *Who will care for us? Addressing the long-term care workforce crisis*. Washington, D.C: Robert Wood Johnson Foundation.

3 United States General Accounting Office. *Nursing Workforce: Recruitment and Retention of Nurses and Nurses Aides Is a Growing Problem*. (Washington, DC., May 2001)
1 Stone, R.I., Reinhard, S.C., Bowers, B., Zimmerman, D., Phillips, C.D., Hawes, C., Fielding, J.A., and Jacobson, N. (2002). *Evaluation of the Wellspring Model for Improving Nursing Home Quality*.

of facility residents, we require that qualified nursing staff provides assistance with eating and drinking, although there is some question whether or not all residents need medical supervision. This group of personnel includes registered nurses, licensed practical nurses, and certified nurse aides who have completed 75 hours of training. However, volunteers, who are usually family members, may also feed residents, because the law and regulations exclude volunteers from the definition of certified nurse aide. Nursing homes in many States report a continuing shortage of certified nurse aides. 1, 2, 3. Nursing homes are finding it increasingly difficult to train and retain sufficient numbers of qualified nursing staff, especially certified nurse aides. Certified nurse aides perform the majority of resident care tasks. Other employers often pay similar wages for less physically and emotionally demanding jobs. This makes it harder for nursing homes to employ enough nursing staff to perform routine nursing care and to feed residents who need minimal help or just encouragement at mealtimes. Feeding residents is often a slow process and competes with more complex tasks, such as bathing, toileting, and dressing changes, as well as urgent medical care. For many elderly nursing home residents, physical and psychological changes often interfere with eating ability and meal consumption. Residents may need assistance with feeding if they have, for example, cognitive impairment, impaired swallowing due to muscular weakness or paralysis, a tendency to aspirate or choke, poor teeth, ill-fitting dentures or partial plates, or poor muscular or

(Modified)

Appendix C

neurological control of their arms or hands, as with Parkinson's disease.

Current Trends

Nursing homes are caring for an aging population that has more acute clinical conditions than in the past. The result is a higher percentage of nursing home residents who need higher levels of care, which takes more staff time and leaves less time for routine tasks, such as ensuring that residents eat their meals and drink enough fluids. In addition, evidence suggests that there has been a recent increase in assisted living facilities that house many individuals with minimal medical needs who previously would have been cared for in nursing homes. Both of these trends have resulted in a frailer nursing home population than previously, with residents who are more dependent on nursing staff for basic needs, such as feeding and personal care. A critical shortage of certified nurse aides in many parts of the country has resulted in a need for staff who are specially trained to help residents eat at mealtimes, to supplement, not replace certified nurse aides. Some residents only need encouragement or minimal assistance, which does not require nursing training. Properly trained non-nursing personnel could provide this type of assistance. Nurse aides and other nursing staff receive training so that they are able to feed residents with all kinds of feeding problems. A higher level of training is required of nurse aides because nurse aides need to be able to deal with complicated feeding problems. However, when there is a nurse aide shortage, it is often the case that residents without complicated feeding problems receive little or no assistance at mealtimes with eating or drinking, while the nursing staff focuses on feeding residents with complicated problems. We believe there is a place in nursing homes for the use of feeding assistants who, after proper basic training in feeding techniques and working with the elderly, are able to feed residents who do not have complicated feeding problems. It is reasonable to require that feeding assistants receive a lower level of training than a nurse aide because feeding assistants would not handle complicated feeding cases. This would allow facilities, if they choose, to train other facility employees as feeding

assistants so that available staff can feed residents at mealtimes.

Facility Staff Shortages

Because of the shortage of certified nurse aides and the increasingly complex medical needs of residents, facilities in some States have used paid feeding assistants to supplement certified nurse aides to ensure that residents take in adequate food and fluids. Generally, feeding assistants used by these facilities are part-time workers, often retired individuals, or homemakers who are available for a few hours a day. They may also be older students who come into the facility between 1 and 2 hours either at the noon or evening meal. In other facilities, staff shortages are so acute that all nonmedical employees, including the administrator of the facility, are required to complete training and help feed residents at mealtimes. Training facility personnel for functions other than their primary position is known as cross-training. There is anecdotal evidence that cross-training of personnel in nursing homes increases coordination and continuity of care.¹ It also contributes to increased morale and lower staff turnover. There is no provision in Federal regulations for the employment of nursing home workers who perform only a single task without completing 75 hours of nurse aide training. Currently, residents must be fed by a registered nurse, licensed practical nurse, or a nurse aide who has completed 75 hours of training and who has been certified as competent to perform all nurse aide tasks. Volunteers may also feed residents. The reason for this existing policy is to ensure that residents who cannot, or do not, feed themselves are fed by trained nursing staff. This is intended to protect residents from unskilled workers who might injure a resident by not recognizing serious medical complications associated with eating. Wisconsin and North Dakota are two States in which nursing homes have had serious difficulty hiring enough certified nurse aides and have used feeding assistants as a supplement to certified nurse aides. Other States have expressed interest in using paid feeding assistants, including Ohio, Minnesota, Florida, California, and

Illinois. Florida and Illinois have both passed laws that permit the use of single task workers in their States, but they have not yet implemented the provisions. Wisconsin nursing homes have been using single-task feeding assistants for more than 7 years. Wisconsin uses a structured, formal program that requires a facility wanting to implement a feeding assistant program to submit an application for approval by the State. The classes are taught by a registered nurse, with a registered dietitian teaching the dietary elements of the program. A facility's approved program must include the following core areas: Interpersonal communication and social interaction; Basic nursing skills (including infection control); Personal care skills (assisting with eating, hydration); Basic restorative services (assistive devices for eating); Resident

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rights; and special problems associated with Dementia (specialized feeding and intake problems). Participants who complete the training must demonstrate skills and pass a written test with a score of 80 percent or better. Feeding assistants are used solely for feeding residents who have no feeding complications. They are permitted to feed residents only in the dining room and operate under the direction of a registered nurse or licensed practical nurse. Feeding assistants serve to supplement care delivered by certified nurse aides, which frees up more extensively trained aides to perform more complex resident care tasks. North Dakota has used paid feeding assistants for a number of years and has a slightly less formal program than that of Wisconsin. The residents to be fed are selected by the dietary and nursing staff. If a facility has a nurse aide training program, the training coordinator and dietitian work together to train new feeding assistants individually. After training and orientation, a new feeding assistant is assigned to one resident who needs minimal assistance. As the assistant gains skill and confidence, he or she is assigned to more residents at

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Appendix C

a meal or to a resident who requires a higher level of skill to feed. Typically, feeding assistants work only about 1½ hours per day, providing assistance at either the noon or evening meal.

Conclusion

We are committed to ensuring that long term care residents receive the best possible care. We recognize that a shortage of certified nurse aides may adversely affect resident care and prevent many residents from receiving adequate help with eating and drinking. Further, we are persuaded by the experience of States that have used paid feeding assistants, that proper training and medical direction of these feeding assistants minimizes the risk to residents, while providing substantial benefits to residents. After thoroughly considering this issue, we believe that the benefits to residents outweigh the potential risks. We believe that a policy change to allow the use of feeding assistants can be accommodated under existing statute. There is nothing in the statute governing requirements for long term care facilities (sections 1819 and 1919 of the Act) that would preclude the use of these workers and we believe that there is no conflict with other statutory requirements.

II. Provisions of the Proposed Regulations

We proposed that feeding assistants must complete successfully a State approved training course that meets minimum Federal requirements specified in proposed § 483.160. These course requirements would consist of relevant items from the nurse aide training curriculum and would include feeding techniques; assistance with feeding and hydration; communication and interpersonal skills; appropriate responses to resident behavior; safety and emergency procedures, including the Heimlich Maneuver; infection control; resident rights; and recognizing changes in residents that are inconsistent with their normal behavior, and the importance of reporting those changes to the supervisory nurse. Facilities or States may want to add items to these minimum requirements.

We proposed that each facility that uses feeding assistants maintain a record of the individuals who have successfully completed the feeding

assistance training. Facilities would be required to report to the State any incidents in which a feeding assistant has been found to neglect or abuse a resident, or misappropriate a resident's property. The State must then maintain a record of all reported incidents.

We proposed that a facility may use a paid feeding assistant to feed residents who do not have a clinical condition that would require the training of a nurse or nurse aide. Selection of residents to be fed would be made by the professional nursing staff, using the comprehensive assessment. Nurses or nurse aides would continue to feed

residents who require the assistance of staff with more specialized training, such as those residents with recurrent lung aspirations, difficulty swallowing, or those residents on feeding tubes or parenteral/IV feedings. Feeding assistants would work under the direct supervision of registered nurses (RN) or licensed practical nurses (LPN), who are in the unit or on the floor where the feeding assistance is furnished. In proposed § 483.75(e), we revised the definition of "nurse aide" to clarify that paid feeding assistants are not performing nursing or nursing-related tasks. Feeding assistants could be paid by the facility or paid under an arrangement with another agency or organization (§ 488.301). Facilities would be able to use staff who are not health care personnel as feeding assistants if they successfully complete the training program. This might include the administrator, activity staff, clerical, laundry, housekeeping staff, or others who see residents on a daily basis. However, feeding assistants are intended to supplement certified nurse aides, not substitute for certified or licensed nursing staff.

We proposed that these requirements would not apply to volunteers and family members.

III. Analysis of and Responses to Public Comments

We received over 6,000 public comments on the proposed rule. About 99 percent of commenters were overwhelmingly supportive of the proposal, but raised a large number of issues and offered many suggestions for clarifications and revisions to the final regulation. Commenters supporting the

proposal included for-profit and not-for-profit nursing homes, national and State nursing home associations, national and State health care associations, State health and human services agencies, United States Congresspersons, and private citizens. Many beneficiary advocates and employee unions opposed giving facilities the option to use paid feeding assistants. A summary of the major issues and our responses follow.

Facility Option To Use Feeding

Assistants Comment: One commenter recommended that we conduct a pilot study or do further research before finalizing the proposal because there is a lack of data that would support the proposal. Another commenter suggested that we implement the proposal, but reevaluate the policy in 3 years to see if the objective is being met.

Response: We believe that the experience of Wisconsin and North Dakota has provided a demonstration of the merits of the use of paid feeding assistants. Both States have reported that in facilities that use feeding assistants, the benefits to residents include fewer cases of unexplained weight loss and dehydration than in facilities that do not use feeding assistants, with no reported ill effects.

Comment: Some commenters believed that the proposal is illegal, that is, there is no basis in the law to support the use of paid feeding assistants.

Response: Our review of the law indicates that there is nothing that would prohibit the use of feeding assistants and we believe that we have the authority and discretion under the law to implement this practice. Although commenters have focused on the language of the statute, at sections 1819(b)(5)(F) and 1919(b)(5)(F) of the Act that requires persons engaged in nursing or nursing related care to be trained either as a nurse or nurse aide, we do not consider the kinds of tasks facilities may ask feeding assistants to provide as either nursing or nursing related. While feeding has been part of the nurse aide training curriculum, that requirement was predicated on the nurse aide having to tend to persons with pronounced eating complications (such as swallowing disorders) for which specialized training is essential.

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What facilities would be free to do as a result of this rule, however, is to use persons who have had a lesser level of training to assist residents who have no feeding issues that require any specialized attention. Thus, we do not consider feeding assistants who may be used by facilities under this rule to be engaged in nursing or nursing related activities.

Comment: Several commenters cited the lack of Federal oversight built into the proposal.

Response: The survey process will provide the Federal oversight of facilities' use of feeding assistants, as it does for other participation requirements. During surveys of nursing homes, surveyors will observe the meal or snack service to note if any of the residents receiving feeding assistance are having trouble, such as coughing or choking. If this is observed, surveyors will investigate to determine if this is an unusual occurrence or a chronic problem and whether feeding assistants have successfully completed the 8-hour training course. Surveyors will also determine if the resident receiving the feeding assistance is one who has no complicated feeding problems. This will be done by a review of medical charts and discussion with the professional nursing staff. Similarly, surveyors will note concerns about supervision of paid feeding assistants and investigate how the facility provides supervision by interviewing staff during meal or snack times and drawing their own conclusions from observations.

Deficiencies will be cited by surveyors when they identify problems. By retaining training and employment records of feeding assistants, a facility will help document its compliance with

Federal requirements, and have a record that surveyors may review when they survey the facility.

Comment: Some commenters were convinced that the use of feeding assistants will not improve the quality of care and may, in fact, lower it. One commenter contended that Wisconsin's use of feeding assistants did not lead to a documented improvement in quality of care. Others commented that use of feeding assistants would disrupt the

continuity of care and reduce quality by creating an assembly line atmosphere.

Response: We are not aware of any data that would suggest that there is an improvement in the quality of care when residents are helped to eat by feeding assistants, nor are we aware of any data that would suggest a decline in quality of care. We are relying on support for the use of paid feeding assistants that has been provided by the Wisconsin and North Dakota survey agencies. Neither agency has indicated that use of feeding assistants has resulted in diminished quality of care.

Comment: A few commenters recommended that we prohibit a facility from training feeding assistants when it has certain deficiencies, in the same way we currently prohibit a facility from training nurse aides. For example, commenters suggested that we prohibit facilities from training feeding assistants if the facility has (1) any deficiency at level F or above; (2) a deficiency at any level in the area of nutrition, staffing, and residents' rights; (3) imposed against it a per instance civil money penalty (CMP) of \$5,000 or more, a per day CMP of \$5,000 or more cumulatively, a State monitor, or temporary manager; (4) an approved nurse-staffing waiver. Several consumer advocacy groups recommended that we limit the authority for a facility to use feeding assistants to facilities that are authorized to conduct nurse aide training programs. In other words, if a facility loses the right to train nurse aides, it should also lose the right to train feeding assistants. Many providers took the opposite position, that a facility that loses nurse aide training rights should retain the right to train feeding assistants.

Response: The prohibition to which commenters refer is a statutory requirement that causes a facility to lose the right to train nurse aides when the facility has certain deficiencies specified in the law. We disagree with commenters and believe that each State needs the flexibility to respond to specific situations and make its own decision whether or not to permit a facility to train and use feeding assistants. Facilities that have an approved nurse-staffing waiver, which waives

requirements in § 483.30 to have a RN on staff 8 hours per day, 7 days per week, are still required to have adequate numbers of LPNs on staff at all times. Thus, even if RNs are unavailable, the supervision requirement for feeding assistants would be met by having LPNs

on duty. *Comment:* Many commenters said that they did not want us to limit hours worked by feeding assistants to mealtimes and advocated permitting feeding assistants to work whenever needed by a facility. Some facilities thought that feeding assistants could be used full time to provide snacks and

liquids to residents, particularly those who cannot leave their room. These commenters believed that this would be a good way to reduce the potential for dehydration since assistants would have time to deliver liquids, provide social stimulation, and encourage bedfast residents to drink more fluids.

Response: The text of the regulations does not limit working hours to mealtimes. According to § 483.35(h), facilities may use feeding assistants at any time that the supervision requirements are met.

Comment: Many providers and individuals expressed strong support for the use of existing staff as feeding assistants, after proper training. A large number of providers reported that they favor this because existing staff, such as clerical, dietary, and housekeeping staff, are already trained in facility policies, are usually well acquainted with residents, and have time available to devote to feeding residents. A number of other commenters were opposed to using existing staff as feeding assistants, citing their full-time responsibilities and concern about added burden.

Response: The text of the proposed regulations permits any individual to act as a feeding assistant if he or she meets the training and supervision requirements (§ 483.35(h)). Each facility's administrator is responsible for allocating available staff to necessary tasks and we believe that it is reasonable to leave the decision to the administrator whether to use as feeding assistants staff who are not health care personnel.

Comment: Some commenters

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suggested requiring that facilities assign feeding assistants to certain residents to ensure continuity of care.

Response: We believe that this decision is best left to each facility and the supervisory nurses.

Comment: Consumer advocates were concerned that insufficiently trained feeding assistants would endanger residents. Other commenters were concerned that feeding assistants might make clinical judgments and take actions that are beyond their scope of training or be unable to handle emergency situations.

Response: The purpose of the training is to ensure that feeding assistants are properly prepared to feed residents and recognize emergency situations that need the immediate help of a supervisory nurse. We believe that a training program that meets the requirements listed in § 483.160 will

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ensure that a feeding assistant receives proper training.

Comment: One commenter suggested that we consider expanding the role and training of feeding assistants so that they can eventually assist in feeding residents with complex feeding problems.

Response: Individuals who have complex feeding problems, such as the need for IV or parenteral feedings, swallowing problems, and those with recurrent lung aspirations, need the assistance of professional nurses or certified nurses aides who have been trained to work with residents who have these needs. We do not believe that it is appropriate for feeding assistants to feed any residents other than those who are low risk and whose eating problems are uncomplicated.

Comment: Two senators and one congressman wrote in support of the proposal, noting the success of one state that used feeding assistants and experienced reduced weight loss and dehydration among nursing home residents. These commenters also reported that the Board of Nursing of one state had defined feeding as a

nursing task and was concerned that this might prevent the state from using feeding assistants. (In the proposal, we indicated that feeding assistants would not be performing nursing or nursing related tasks.) Another commenter believed that feeding is a nursing related service and should not be performed by an individual with minimal training.

Response: The definition of the term, "nursing and nursing-related tasks," is frequently prescribed by State law and, therefore, we are declining to impose a Federal definition of this term on all States. We believe the matter should be left with the State in those situations in which State law or standards-setting organizations have established a definition that is more restrictive than the Federal definition permitting the use of feeding assistants. We suggest that the State investigate whether a revision to State law would resolve this issue.

Staffing Issues

Comment: One consumer advocacy group suggested that we require state survey agencies to use the investigative protocol for staffing from the *State Operations Manual* in all facilities that request to use or use feeding assistants. This protocol, used to identify problems that may be associated with insufficient nursing staff, would ensure that a facility has an appropriate number of RNs and LPNs to supervise feeding assistants.

Response: We believe that facilities that request to use or use feeding assistants should be surveyed in the same way as any other facility.

Surveyors should use the investigative protocol for staffing only when systemic problems relate to insufficient nursing staff.

Comment: A consumer advocate asked that we require facilities to post information about the numbers of feeding assistants, in addition to the current requirement to post the number of licensed and unlicensed staff employed per shift. The commenter also suggested that we require that feeding assistants wear badges or name tags so that they will be clearly recognized by other staff.

Response: A provision in the Medicare, Medicaid & State Child Health Insurance Program (SCHIP)

Benefits Improvement & Protection Act of 2000 (BIPA) requires facilities to post daily for each shift the current number of licensed and unlicensed nursing staff directly responsible for resident care in the facility. This provision is effective January 1, 2003. Because paid feeding assistants do not qualify as licensed or unlicensed nursing staff, facilities do not need to post the numbers of feeding assistants used by the facility. However, we will consider at a later date whether this might be useful and what additional burden it may impose on facilities. With regard to name tags, we believe it is probably a good idea, but leave that decision to each facility and do not see the need for us to make this a requirement.

Use of Volunteers

Comment: Several commenters suggested that we require volunteers to complete the training requirements for feeding residents, pointing out that it is inconsistent not to do so.

Response: While we believe that it is a good idea for family members and volunteers to take the training, and we encourage it, we are not making this a requirement. Many volunteers in facilities are family members who are only there to feed a relative. Often, family members have been feeding the ailing resident for years, both at home and in the facility. We are leaving it to each facility to determine whether or not to require volunteers and family members to complete feeding assistance training. Ultimately, facilities are responsible for the care and safety of residents, even if the resident is fed by a relative or friend.

Payment Issues

Comment: Some providers were concerned about how they would be paid for the training and services of feeding assistants. A few commenters recommended that we allocate payment for feeding assistants to the nursing cost center.

Response: Skilled nursing facilities will not receive additional Medicare payment for the costs of using feeding assistants. Medicare payment for residents in skilled nursing facilities is made through a prospective payment system, which covers all costs (routine, ancillary, and capital) of covered skilled nursing facility services furnished to beneficiaries under Part A of the Medicare program. For Medicare

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payment, the term and concept, "nursing cost center," is outdated, but still may be used in some State Medicaid programs. The Medicare SNF PPS per diem payment rate is based, in part, on levels of care and resources required and received by residents, established by the resident assessment instrument specified in § 483.20. The system does not require that tasks performed by a staff person fit within a direct care or indirect care category (such as a nursing cost center). Medicaid payments for nursing facilities are established by each State.

Therefore, it would be up to individual States to determine whether they would need to change their payment rates for those facilities that use feeding assistants and how the rates would be changed. However, because feeding assistants will likely be paid at a minimum wage, which is less than the wage paid to certified nurse aides, facilities participating in Medicare and Medicaid may incur less cost than if they had hired additional certified nurse aides to perform feeding and hydration duties.

Comment: One provider reported using workers who pass out trays, provide beverages and condiments, talk to and encourage residents, record food intake, and perform routine dining room tasks. The commenter asked if the facility would be able to continue to use these workers.

Response: A facility may continue to use workers who perform the dietary service functions described by the commenter. They need not be trained as feeding assistants if they do not feed residents. Facilities are required to employ sufficient support personnel to carry out the functions of the dietary service. If these workers successfully complete the feeding assistant training course, the facility may also use them to feed residents. However, as we indicated in the last response, the Medicare program pays skilled nursing facilities a prospectively determined per diem rate, which does not require that

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tasks performed by personnel fit into a direct or indirect care category. For Medicaid payment, payment is determined by each Medicaid state agency.

Determining Which Residents Can Be Fed by Feeding Assistants

Comment: One state commented that it is cumbersome to rely on the comprehensive assessment to determine which residents may be safely fed by a feeding assistant. Instead, the decision should be left entirely up to the professional judgment of the licensed nurse. A consumer advocacy group also indicated that the comprehensive assessment/annual evaluation is not an effective tool for the assessment of residents to be fed because the information may not be current. Several organizations suggested that we emphasize the importance of the RN or LPN's professional judgment along with input from the interdisciplinary team, as reflected in the comprehensive assessment, when selecting residents for feeding assistance.

Response: We agree with commenters and are revising § 483.35(h)(1)(ii) to say that the decision about whether a resident is to be fed by a feeding assistant is based on the charge nurse's assessment and the resident's latest assessment and plan of care. We note that facilities that choose to use paid feeding assistants remain responsible for any adverse actions resulting from the use of these assistants, as with any other employee.

Comment: An organization representing licensed professionals suggested that the RN or LPN should consult with a speech-language pathologist when a resident is suspected to have, or is at risk for, swallowing difficulties.

Response: We have no objection to this and facilities may use this approach if they choose.

Comment: Several commenters indicated that the criteria for selecting residents to be fed is inadequate and suggested that we define the clinical conditions that would require feeding by an RN or LPN or nurse aide. Another

commenter suggested that we prohibit feeding assistants from feeding residents with swallowing problems.

Response: We believe that the clinical decisions as to which residents may be fed by feeding assistants are best left to the professional judgment and experience of RNs and LPNs who work in the facility and have personal knowledge of a resident's day-to-day condition. If we were to define clinical conditions, we would only be substituting the judgment of professional nurses employed by the Federal government for the judgment of nurses working in facilities. We believe that professional nurses conclude that certain clinical conditions relating to eating and drinking would require the skills and knowledge of an RN or LPN.

These conditions include, but are not limited to, recurrent lung aspirations, difficulty swallowing, and tube or parenteral/IV feedings.

Comment: One commenter suggested a number of more stringent requirements for facilities, including (1) obtaining informed consent from the resident or resident's representative that the resident agrees to be fed by a feeding assistant and accepts the risks and benefits; (2) an individualized feeding plan; and (3) a certification by a licensed nurse in a resident's medical record that the resident can be safely fed by a feeding assistant prior to each instance of feeding.

Response: We understand that the commenter intends the proposed provisions to be in the best interest of residents, but we believe that, for the most part, they are unduly burdensome for facilities to implement. To require consent before a resident can receive help from a feeding assistant implies that this is a high risk procedure, which we believe it is not. We believe that the Wisconsin and North Dakota experience indicates that it is safe to use well trained feeding assistants who are properly supervised. It would be inconsistent to require residents to give informed consent for feeding assistance when they need not do so for any other services provided by a facility. Further, a feeding plan would very likely duplicate part of the care planning process. Consequently,

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we are not revising the rule to accommodate the commenter's suggestions.

Supervision

Comment: Commenters, concerned about lack of supervision, pointed out that the proposed requirement, in § 483.35(h)(2)(ii), that a nurse is in the unit or on the floor, exceeds the licensed nursing requirements in most states. Other commenters worried that the shortage and high turnover rates of licensed and unlicensed nursing staff could mean that fewer staff are familiar with residents and could result in inadequate monitoring.

Response: Facilities are required by § 483.30, Nursing services, to have sufficient qualified nursing staff available on a daily basis to meet residents' needs for nursing care. The requirement in § 483.30, Nursing services, is that, unless waived, a facility must have a RN on duty 8 consecutive hours per day, 7 days a week. A facility must also have a sufficient number of licensed nurses and other nursing personnel on a 24-hour basis to provide nursing and related services to residents. The proposed requirement that a feeding assistant work under the direct supervision of a RN or LPN builds on the requirement that sufficient licensed nursing staff are on duty 24 hours a day. We believe that, if a facility chooses to use feeding assistants, it is the facility's responsibility, and in its best interest, to ensure that adequate supervisory nursing staff is available.

However, we recognize that the supervision requirement is unclear and subject to a variety of interpretations. Therefore, we are revising § 483.35(h)(2) by removing the word, "direct" from the phrase, "direct supervision," because it may unintentionally imply visual contact between a feeding assistant and a supervisory nurse. This is not possible in most facilities, especially if assistants are feeding residents in their rooms. Next, we are removing the requirement that a nurse be in the unit or on the floor

where the feeding assistance is furnished and immediately available to give help. As commenters noted, this sentence is unclear. While we are not prescribing the precise means by which facility RNs or LPNs assert their supervisory responsibilities, we

will expect that facilities do so in a way that avoids negative outcomes for their residents. Additionally, we are requiring that a feeding assistant call a supervisory nurse on the resident call system when there is an emergency or a need for help. All facilities are currently required to have a resident call system.

Comment: Consumer advocates expressed concern about a potential lack of supervision and suggested that all residents who are fed by feeding assistants be fed in the dining room or other congregate area to ensure that a licensed nurse is physically present. Other commenters supported allowing feeding assistants to feed residents in their rooms, citing the fact that many of the most frail residents do not go to the dining room and are least likely to get adequate assistance with eating. Numerous commenters cited examples of bedfast residents, unable to feed themselves or reach the food, receiving no help at mealtime, after which the tray is removed, untouched by the resident.

Response: We share commenters' concerns about adequate supervision of feeding assistants to ensure the safety of residents. We are equally concerned, however, that those residents who are unable or unwilling to go to a congregate dining area receive needed feeding assistance in their rooms. We are confident that the nurse in charge, using his or her professional judgment in assessing residents who are appropriate for feeding assistance, will be able to select residents who can safely be fed in their own rooms.

Comment: An organization representing nursing home employees noted that nursing staff is already overworked and supervising feeding assistants would only add to the burden. Another commenter indicated that the proposed supervision requirement would further burden RNs and LPNs because they would have to stay in the dining room during mealtimes and this would limit their availability elsewhere in the facility.

Response: Adequate supervisory staff is just one factor that a facility needs to consider when deciding whether or not to use feeding assistants. If a facility chooses to use paid feeding assistants, it would be the facility's responsibility to ensure that it has sufficient

RNs and LPNs available to adequately supervise feeding assistants without adding undue burden on the staff. When using feeding assistants, there will be a need for a facility to balance the increase in staff available to meet resident needs with the increased need to supervise these assistants.

Training

State-Approved Training Course

Comment: Several providers asked whether facilities would be able to hire paid feeding assistants if the State does not approve a training program for feeding assistants. Many providers supported giving facilities maximum flexibility to implement the proposal without lengthy state approval requirements. One commenter suggested that we require all states to mandate feeding assistant programs in all facilities. Other commenters believed that, before facilities may opt to use feeding assistants, States should be able to decide whether implementing feeding assistant programs is in the best interest of the State or consistent with State law. Several providers, provider organizations, and States asked that we remove the requirement that a training course for feeding assistants be State approved, citing potential burden on States, cost, and delays in implementing feeding programs. One State with a large number of facilities and a shortage of resources was concerned about the potential burden of approving a large number of feeding programs. Commenters, instead, suggested that we require that an individual complete a training course that meets the requirements of § 483.160. In this case, the facility would maintain documentation of compliance with the requirements and surveyors would review the training records at annual surveys. Many states and providers asked for clarification on our expectations in terms of state approval. They wondered whether other entities, such as community colleges, would be permitted to offer the training. One commenter noted that travel to community colleges and cost would discourage individuals from taking the training. There was also a question about the frequency with which a state would need to review or reapprove a feeding assistant program. Another commenter suggested that we offer more specific guidance to states to assist them

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in establishing criteria for training programs and others suggested using established models from Wisconsin and North Dakota.

Response: We have chosen to retain the requirement that States approve training programs for feeding assistants. We believe that this will give States the necessary control and flexibility to structure approval processes for training programs to fit the needs of each State. States that have large numbers of facilities and resources that are stretched to the limit may want to minimize any burden associated with State approval of training programs, while States with fewer facilities may structure approval in a very different way. However, States also have the flexibility not to implement a program for approval of feeding assistant training programs. If a State does not implement an approval program, the result is that facilities in that State will not be able to hire any paid feeding assistants.

Training Content

Comment: We received a variety of comments on training, including requests for additional requirements, removal of requirements, and clarifying changes. Many commenters asked that we provide more specificity on training requirements and establish a minimum number of hours of training. Suggestions for hours of training ranged from 5 to 75.

Response: We believe that being overly prescriptive on the content of training is unnecessary, would reduce flexibility to offer these training programs, and would unnecessarily limit the ability of States and providers to develop these programs within the scope of their considerable knowledge.

However, to ensure that training is not conducted in a superficial manner, we are revising § 483.160(a) to require that a training course for feeding assistants include, at a minimum, 8 hours of training.

Comment: A few commenters suggested that we specify in the text of the regulation that a feeding assistant must "successfully" complete the entire training course before he or she is qualified to work with residents in the facility.

Response: We agree with the commenters that successful completion of the training course is essential and are

revising § 483.35(h)(2)(i) by adding the word "successful." We believe that it is reasonable to expect that a feeding assistant will successfully complete the training course before working directly with residents. This is a basic safety precaution to ensure that residents are protected. After completion of training, a facility may want to slowly ease a feeding assistant into the work by feeding a resident who needs minimal assistance, as North Dakota does.

Comment: Many commenters advocated requiring a competency test before feeding assistants are permitted to work with residents.

Response: We are not including a requirement for a competency test in the final rule. We believe that the instructor or supervisory nurse will be able to assess the competency of trained feeding assistants.

Comment: Several commenters objected to the inclusion of the Heimlich Maneuver in the training course and its use by feeding assistants. They were concerned that its use by a robust feeding assistant on a frail resident might result in rib fractures or other injuries. Commenters emphasized that only nursing staff should determine the need for, and administer, the Heimlich Maneuver. Instead, they suggested that the training course emphasize the need for feeding assistants to recognize symptoms that should be immediately reported to licensed supervisory staff for further action.

Response: The Heimlich Maneuver is an emergency procedure that is taught to the public, as well as medical personnel. It seems reasonable to retain this training requirement in view of the fact that nurse aides are trained to use this procedure and they may also be strong individuals. Proper training is essential and feeding assistants will receive the same training on the Heimlich Maneuver as nurse aides. Also, experienced RNs tell us that training in handling emergencies will

procedure like the Heimlich.

Comment: One commenter suggested that, if a facility uses a feeding assistant under an arrangement with another organization, the facility must verify that the feeding assistant has successfully completed the training.

Response: Section 483.35(h)(2) already provides for this. It says that, if a facility uses a paid feeding assistant, the facility must ensure that the individual has completed a State approved training course. The burden of proof is on the facility to ensure that any feeding assistant it uses is properly trained.

Comment: Commenters suggested a number of additions to the general training requirements. One suggestion was to require that training programs explicitly include feeding problems of the cognitively impaired, since 60–70 percent of nursing home residents are cognitively impaired. Other suggestions included training in dementia, food and drug interactions, diet consistencies, how much and how to feed, resident preferences, difficulty swallowing, and emphasis on performing only feeding tasks for which training has been provided. A consistent concern of commenters was a need for a training emphasis on recognition and prevention of emergency situations associated with feeding, such as dysfunctional swallowing, tracheal aspiration, esophageal obstruction, and other potentially severe emergency situations.

Response: It is important to note that the training course requirements proposed in § 483.160 are minimum requirements. States and facilities are free to add to those requirements. However, many of the training additions suggested by commenters appear to be more useful in the training of nurse aides than feeding assistants, who will feed residents without any significant eating problems.

Comment: Several commenters suggested that we address payment for training in the same way that we do in the regulations for nurse aides. One commenter asked that we prohibit facilities from charging potential feeding assistants for training. Another asked if a facility may require that a trained feeding assistant repay the facility for

55535 Federal Register / Vol. 68, No. 187 / Friday, September 26, 2003 / Rules and Regulations emphasize the need for a feeding assistant to call for help immediately, and then, if necessary, begin a

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training if he or she leaves? A commenter asked if a facility can require that a trained feeding assistant work for a set period of time.

Response: Judging from provider comments received, there will be a strong demand for feeding assistants and it is unlikely that facilities will want to charge for training. Generally, these positions will be part time and will not require extensive training that would be costly for the facility. We think it is unnecessary to amend the regulations to provide for payment provisions similar to those for nurse aides. With regard to a facility entering into a contract with a feeding assistant that would require that individual to work for a certain period of time, there is nothing in our regulations that would prohibit this practice. This is strictly between the facility and the feeding assistant.

Qualifications of Instructors

Comment: Many individual commenters and professional organizations asked that we establish standards or qualifications for instructors of the training program. Commenters suggested numerous licensed or certified health care professionals who could conduct the training, including RNs, registered dietitians, licensed physical therapists, licensed speech therapists, and occupational therapists. Dietitians argued that they have the expertise in food and nutrition issues in long-term care settings, are trained to teach self help feeding devices, and basic restorative feeding services, citing established manuals and materials that would support this practice. Occupational therapists argued that they are trained to match an analysis of disabilities with effective interventions, resources and adaptations. Several commenters strongly recommended that we prohibit feeding assistants from teaching each other on the-job.

Response: It is apparent that a number of options are available in terms of the variety of licensed or certified health care professionals that may be qualified to conduct training for feeding assistants. Some, RNs and LPNs, are employed full time in facilities and would be available without additional cost to conduct the training. Dietitians

may be employed by a facility full time, part time, or on a consultant basis. Other health care professionals may be available at additional cost; however we believe that it would be inappropriate to permit a feeding assistant to train another. Consistent with the flexibility for States to develop a State-approved training program, we are deferring to

States the decision as to which individuals would be qualified to teach the feeding assistant training.

Maintenance of Records

Comment: Several commenters pointed out that there is no requirement for states to maintain a formal registry of feeding assistants or to check with other states for background information. One commenter suggested that states report information on feeding assistants to the nurse aide registry and provide this information to facilities for hiring purposes. Others suggested that we require facilities to check with the nurse aide registry before employing individuals as feeding assistants in case the individual had worked as a nurse aide previously.

Response: We have decided to include only nurse aides in the nurse aide registry, largely because the law is so specific about the requirements. Also, we believe it is not necessary to further burden States by requiring them to establish and maintain a separate registry for feeding assistants. As we explain later in the preamble, states are already required by § 488.335 to review and investigate all allegations of abuse, neglect, and misappropriation of resident property. This information can be accessed by any hiring facility. Facilities need to screen feeding assistants, as any other employee, to try to ensure that individuals have no history that would preclude their interaction with frail elderly residents.

Comment: Several commenters reported that there is no provision for feeding assistants trained in one facility, city, or state to carry that training forward so that it does not have to be repeated. There is no requirement for a facility to request a copy of an individual's training record before he or she is hired as a feeding assistant. A commenter suggested that we establish a requirement for states to have

reciprocity agreements within each state or between states.

Response: It is not our intent that individuals repeat training when moving to another facility. However, we believe that it is unnecessary to establish extensive regulatory provisions for requesting records or for state reciprocity agreements in this case. As with any other job applicant, a feeding assistant should indicate where he or she was last employed and a hiring facility may contact the former employer to verify employment and training. States are currently required to review allegations of abuse, neglect, or misappropriation of resident property. A hiring facility should be able to contact the state for that information.

Reporting Abuse, Neglect, and Misappropriation of Residents' Property

Comment: Commenters had a number of suggestions concerning proposed § 483.160(c), which requires a facility to report to the state all incidents of a paid

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feeding assistant who has been found to neglect or abuse a resident, or misappropriate a resident's property. That section also requires a state to maintain a record of all reported incidents. One state reported that it already has a requirement for criminal background checks and a law requiring that facilities report allegations of abuse and neglect. Other commenters suggested language changes to the text. One commenter noted that § 483.160(c) is inconsistent with § 488.335, which requires a state to review all allegations of resident neglect, abuse, and misappropriation of property, and follow procedures in § 488.332. Section 488.332 requires a state to establish procedures to investigate complaints of participation requirements.

Response: We agree with the commenter regarding requirements in proposed § 483.160(c). Paragraph (c) is unnecessary because it repeats certain provisions of existing § 488.335. Since § 488.335 already establishes state requirements for review of allegations of

(Modified)

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neglect, abuse, misappropriation of property, and procedures for investigation of complaints and hearings, we are removing proposed paragraph (c) in § 483.160.

Definition of Paid Feeding Assistant

Comment: Many commenters objected to the term, feeding assistant, saying that it has a pejorative connotation and it lacks sensitivity to the elderly. Others thought that the term failed to include the importance of fluid intake. Commenters suggested a variety of alternatives, including the following: meal assistant; food and hydration aide or assistant; nourishment aide, nutrition assistant, nutritional aide, nutrition/hydration assistant; dining assistant; and resident assistant.

Response: The commenters make a good point, which we had not recognized when drafting the proposal. However, the term, feeding assistant, was widely used by states and organizations before our proposal. Rather than change the term in the regulations, we suggest that facilities and states use whatever term they prefer.

IV. Provisions of the Final Regulations
For the most part, this final rule incorporates the provisions of the proposed rule. The following provisions of this final rule differ from the proposed rule:

- We are reorganizing and revising § 483.35(h) so that paragraph (h)(1) applies to State approval of training courses for feeding assistants. We are adding the requirement that a feeding assistant must successfully complete a State-approved training course, and do so before feeding residents.
- Also, in revised § 483.35(h)(1), we are clarifying that a facility may use a paid feeding assistant if it is consistent with State law.
- In revised § 483.35(h)(2), we are revising the supervision requirement to remove the word, "direct," from the phrase, "direct supervision."
- Also, in revised § 483.35(h)(2), we are removing the requirement that a supervisory nurse be in the unit or on the floor where the feeding assistance is furnished and is immediately available to give help, if necessary. In place of that sentence, we are adding the requirement that a feeding assistant call a supervisory

nurse for help during an emergency on the resident call system.

- In revised § 483.35(h), we are adding a new paragraph (3) concerning resident selection criteria to replace proposed § 483.35(h)(1)(ii). In new paragraph (3), we are replacing the term, "clinical condition" with the phrase, "complicated feeding problem."
 - In § 483.35, we also specify that a complicated feeding problem includes, but is not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.
 - Also, in § 483.35, we provide that a facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care.
 - In § 483.160(a), we are adding a requirement that the State-approved training course include a minimum of 8 hours of training covering the topics listed in § 483.160(a).
 - In § 483.160(c), we are removing the requirement that a facility report to the State all incidents of a paid feeding assistant who has been found to neglect or abuse a resident, or misappropriate a resident's property, and that a State must maintain a record of all reported incidents. This paragraph unnecessarily duplicates existing requirements in § 488.335, Action on complaints of resident neglect and abuse, and misappropriation of resident property.
- V. Collection of Information Requirements
- Under the Paperwork Reduction Act of 1995, we are required to provide 30-day notice in the Federal Register and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether OMB should approve an information collection, section 3506(c)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:
- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
 - The accuracy of our estimate of the information collection burden.
 - The quality, utility, and clarity of the information to be collected.

• Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Nursing homes in two States currently use feeding assistants and eight other States have expressed an interest in implementing this policy. While public comments from nursing homes and provider organizations indicated strong support for the use of feeding assistants, only 13 States responded to the proposal. Some States indicated interest and others had concerns about the cost of implementation and other issues, so

we do not now have a better idea of how many States will choose to approve the use of feeding assistants in nursing homes. In addition, it remains a facility option, so we still do not know how many facilities in which States will choose this option, nor do we know how many feeding assistants would be used by each facility. There are approximately 17,000 nursing homes in the nation, and they are not evenly distributed within States. Wisconsin reported that about 25 percent of nursing homes in the State used feeding assistants. On a nationwide basis, we believe that it is reasonable to project that 20 percent of facilities will use feeding assistants. We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements: *Section 483.160(b)*

1. Requirement

A facility must maintain a record of all individuals, used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants.

2. Burden

We estimate that 20 percent of nursing homes may implement this policy (20 percent of 17,000 = 3,400 facilities/respondents). If we assume that each facility will hire two feeding assistants, this results in a total of 6,800 feeding assistants. Depending on the method chosen by a facility to collect this information, we believe that each facility (respondent) would spend no more than 30 minutes per month (6 hours per year) entering feeding assistant information into its record-

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keeping system. Some months, facilities may have no information to add. With 3,400 facilities at 6 hours/year, the total would be 20,400 hours for facilities. Using a clerical wage cost of \$10 per hour, the total facility burden is estimated to be \$204,000. We are submitting a copy of regulation § 483.160 to OMB for its review of the information collection requirements. The revision is not effective until OMB has approved it. If you comment on these information collection and record keeping requirements, please mail copies directly to the following addresses:

Centers for Medicare & Medicaid Services, Office of Information Services, Information Technology Investment Management Group, Attn.: Julie Brown, Room C5-16-03, 7500

Security Boulevard, Baltimore, MD

21244-1850; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive

Office Building, Washington, DC 20503, Attn: Brenda Aguilar, CMS Desk Officer.

Comments submitted to OMB may also be emailed to the following address: email: baguilar@omb.eop.gov; or faxed to OMB at (202) 395-6974.

VI. Regulatory Impact Statement
A. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), and Executive Order 13132. Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA)

must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). This rule is not a major rule. The costs of using feeding assistants will be covered by existing Medicare payment and, most likely Medicaid payment, depending on how a State establishes payment rates. Skilled nursing facilities receive an all-inclusive per diem Medicare payment rate for each resident's care. This includes all costs (routine, ancillary, and capital) of covered skilled nursing facility services furnished to beneficiaries under Part A of the Medicare program. Skilled nursing facilities will not receive additional Medicare payment for the costs of using feeding assistants. Medicaid payments for nursing facilities are established by each State.

Therefore, it would be up to individual States to determine whether they would need to change their payment rates for those facilities that use feeding assistants and how the rates would be changed. However, because feeding assistants will likely be paid at a minimum wage, which is less than the wage paid to certified nurse aides, facilities participating in Medicare and Medicaid that use feeding assistants may incur less cost than if they had hired additional certified nurse aides to perform feeding and hydration duties. State costs associated with feeding assistant training programs are considered administrative expenses and are funded under Medicaid with

matching funds at 50 percent Federal financial participation. Any information we have on potential State costs of implementing feeding assistant programs comes from States that have used such programs in the past. One State, Wisconsin, has a well-structured program and has experienced relatively minimal costs. One registered nurse spends approximately 10 percent of her time reviewing and approving facility feeding assistant training programs. This represents 10 percent of a full-time equivalent position (FTE), which is reported by Wisconsin to be a cost of about \$7,000 per year. At a time when the use of feeding assistants was highest, a quarter of Wisconsin's 420 nursing homes, or 100 to 110 facilities, used feeding assistants. The number of feeding assistants

used by each facility varies according to the size of the home, with the maximum number estimated to be 5 for a large, 200- to 250-bed home. Feeding assistants are typically paid at the same minimum wage. The number of hours each feeding assistant works at a facility is also variable and different for each worker and facility. Further, some facilities use only existing staff as trained feeding assistants. Because of the number of hours worked by each feeding assistant is variable, we do not have an exact estimate of the total cost to Wisconsin for using feeding assistants. However, this summary of Wisconsin's program may be helpful to other States, which are interested in establishing feeding assistant programs. The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small government jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of \$6 to \$29 million in any 1 year. For purposes of the RFA, all long-term care facilities are considered to be small entities. Individuals and States are not included in the definition of a small entity. The Small Business Administration considers 62 percent of long term care facilities to meet their definition of small entity (those facilities with total revenues of \$11.5 million or less in any 1 year. We have determined that this rule will affect these entities, but, in general, we expect any cost to be covered by Medicare and Medicaid program payments. In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. This final rule does not affect small rural hospitals. For these reasons, we are not

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preparing analyses for either the RFA or section 1102(b) of the Act because we have determined that this rule will not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals. Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of \$110 million. This final rule will not have a cost greater than \$110 million on the governments mentioned or on the private sector. In general, we believe that existing Medicare and Medicaid payments will cover the facility costs of using feeding assistants. Costs associated with surveys of long term care facilities are Federally funded, as are costs of State approval of training programs. Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We believe that this rule contributes to State flexibility by giving States the option to allow the use of feeding

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assistants, control over how to structure the process of the approval of facility feeding assistant programs, and over elements of training, including instructor qualifications. In this way,

States can establish policies that fit their unique circumstances. We believe that this rule will not have a substantial effect on State or local governments.

B. Anticipated Effects

These provisions will affect long term care facilities. We expect the provisions to be a substantial benefit both to facilities that are short-staffed and to residents who need help with eating and drinking. By using feeding assistants to help residents with eating and

drinking, facilities can use trained, certified nurse aides to perform other, more complex resident care tasks.

Based on the large number of comments we received from nursing homes in a variety of States, we now believe that there is widespread support for the proposal and widespread intent to implement the provisions. However, because this is an optional provision, and some States may have legal barriers to implementation, we do not know how many States or facilities may implement these provisions, or how many feeding assistants will be used by facilities. Based on public comments, we anticipate that some facilities may hire no additional staff as feeding assistants, opting instead to use existing staff whose primary function is not direct care of residents, such as administrative or activities staff. We believe that feeding assistant training most likely will be conducted by existing facility staff and that there will be some nominal training costs to the facility since training requires time away from other duties that other staff

State-Approved Training Programs

We require that a feeding assistant successfully complete an 8-hour State approved training course, which meets the Federal requirements in § 483.160(a). We have established no requirements on how States are to approve these programs, thereby giving each State the flexibility to decide what method makes the most sense in terms of use of its resources. There are several

ways in which States may approach approval of training programs. States might choose to develop a model training program that complies with Federal requirements and require that any facility that trains and uses feeding assistants use that specific program. One model might be based on an existing training program already established, such as those conducted in Wisconsin or North Dakota. A State might choose to do a paper review of each facility's training program, or the State might insist on a site visit to review a facility's program. Lastly, a State might initially deem each facility's training program approved and then review the program when the facility is next surveyed. For

some of these options, a State may need additional staff hours to review and approve training programs. However, States already review and approve training programs for nurse aides, so there is an existing administrative structure in place. There is the potential for increased State costs associated with review and approval of facility feeding assistant programs. However, any cost will depend on the approval method that is chosen by each State.

1. Effects on the Medicare and Medicaid programs.

There are approximately 17,000 facilities nationally. Long term care facilities that participate in the Medicare and Medicaid programs must provide the necessary care and services to residents so that they attain or maintain the highest practicable physical, mental, and psychosocial well being. To do this, facilities must employ sufficient staff on a 24-hour basis, including nursing staff, administrative, medically-related social services, dietary, housekeeping, and maintenance staff. The Medicare program pays for skilled nursing facility services to eligible beneficiaries through a prospective payment system that covers all costs of covered services furnished to residents on a per diem basis. This Medicare SNF PPS per diem payment rate is based, in part, on levels of care and resources required and received by residents. The payment rate covers all care required and received by a resident and does not require that tasks performed by a staff person fit within a direct or indirect care category.

Therefore, the Medicare program would not pay a skilled nursing facility any additional funds if the facility chooses to use feeding assistants. Medicaid payments for nursing facilities are established by each State. Therefore, it would be up to individual States to determine whether they would need to change their payment rates for those facilities that use feeding assistants and how the rates would be changed.

C. Alternatives Considered

There has been a continuing shortage of certified nurse aides in recent years, along with a shortage of RNs and LPNs willing to work in nursing homes. Certified nurse aides perform the majority of resident care in a long term care facility and are the

(Modified)
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lowest paid workers, while RNs and LPNs receive higher wages commensurate with their advanced training, experience, and supervisory responsibilities. One alternative to the use of paid feeding assistants is to broaden the hours during which meals are served so that everyone is not fed at the same time within a one-hour mealtime. Expanded meal service, covering perhaps a 3-hour mealtime, or a restaurant model, where meals are available most of the time, would allow existing staff more time to help feed residents. However, this option already exists in regulations, and other than a few innovative facilities, nursing homes have chosen not to use this method. The current preference of most nursing homes is for an institutional approach in which meals are served to all residents early morning, noon, and evening at fixed hours. As a result, the nursing home industry prefers the use of feeding assistants rather than an expanded meal service. The other alternative is not to publish a regulation on the use of feeding assistants and, instead, make greater use of volunteers to assist with feeding. The use of volunteers to assist with feeding assistance is permitted in the current regulations. However, it is questionable whether facilities could find sufficient numbers of volunteers to meet their needs.

D. Conclusion

We believe that both residents and providers will benefit from these provisions. Residents will receive more assistance with eating and drinking, both at meals and at snack time. Facilities will be able to use existing staff to assist at mealtimes and hire additional staff to meet the needs of residents, freeing certified nurse aides to perform more complex tasks that require their training. In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects 42 CFR Part 483

Grant programs—health, Health facilities, Health professions, Health records, Medicaid, Medicare, Nursing homes, Nutrition, Reporting and record keeping requirements, Safety.

42 CFR Part 488

Health facilities, Medicare, Reporting and record keeping requirements.

HFAM QIC, October, 2003
Revised March, 2004

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_ For the reasons set forth in the preamble, CMS is amending 42 CFR chapter IV as set forth below:

_ A. Part 483 is amended as follows:
PART 483—REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES

Subpart B—Requirements for Long Term Care Facilities

_ 1. The authority citation for part 483 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

_ 2. In § 483.35, the introductory text is republished, paragraph (h) is re-designated as paragraph (i), and a new paragraph (h) is added to read as follows:
§ 483.35 Dietary services.
The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

(h) *Paid feeding assistants*—(1) *State-approved training course*. A facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if—

(i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of § 483.160 before feeding residents; and
(ii) The use of feeding assistants is consistent with State law. (2) *Supervision*. (i)

A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN).

(ii) In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system.

(3) *Resident selection criteria*.

(i) A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems.

(ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.

(iii) The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care.

§ 483.7 [Amended]

_ 3. Section 483.7 is amended as follows:

_ a. In paragraph (e)(1), the definition of "Nurse aide" is amended by adding a sentence to the end of the definition;

_ b. A new paragraph (q) is added.

The additions read as follows:

§ 483.75 Administration.

(e) *** (1) ***

(1) *** Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in § 488.301 of this chapter.

(q) *Required training of feeding assistants*. A facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants, as specified in § 483.160 of this part.

Subpart D—Requirements That Must Be Met by States and State Agencies:

Nurse Aide Training and Competency Evaluation; and Paid Feeding Assistants

_ 4. The heading of subpart D is revised to read as set forth above.

_ 5. A new § 483.160 is added to read as follows:

§ 483.160 Requirements for training of paid feeding assistants.

(a) Minimum training course contents.

A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following:

- (1) Feeding techniques.
- (2) Assistance with feeding and hydration.
- (3) Communication and interpersonal skills.
- (4) Appropriate responses to resident behavior.
- (5) Safety and emergency procedures, including the Heimlich maneuver.
- (6) Infection control.
- (7) Resident rights.
- (8) Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse.

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(b) Maintenance of records. A facility must maintain a record of all individuals, used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants.

_ B. Part 488, subpart E is amended as follows:

PART 488—SURVEY, CERTIFICATION, AND ENFORCEMENT PROCEDURES
Subpart E—Survey and Certification of Long Term Care Facilities

_ 1. The authority citation for part 488 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1895hh).

_ 2. Section 488.301 is amended by adding a new definition of "Paid feeding assistant" in alphabetical order to read as follows:

§ 488.301 Definitions.

As used in this subpart—

Paid feeding assistant means an individual who meets the requirements specified in § 483.35(h)(2) of this chapter and who is paid to feed residents by a facility, or who is used under an arrangement with another agency or organization.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program) Dated: May 22, 2003.

Thomas A. Scully,
Administrator, Centers for Medicare & Medicaid Services.

Approved: June 24, 2003.

Tommy G. Thompson, *Secretary.*

[FR Doc. 03–24362 Filed 9–25–03; 8:45 am]

BILLING CODE 4120–03–U

LEGAL SERVICES CORPORATION

45 CFR Part 1626

Alien Eligibility for Representation by LSC Programs

AGENCY: Legal Services Corporation.

ACTION: Final rule.

SUMMARY: The Legal Services Corporation ("Corporation") is revising the appendix to its regulations on restrictions on legal assistance to aliens. This appendix sets forth a listing of documents upon which recipients may rely to verify the eligibility of non-U.S.

citizens' applicants for legal assistance from LSC-funded programs.

EFFECTIVE DATE: This rule is effective as of September 26, 2003.

FOR FURTHER INFORMATION CONTACT:

Mattie C. Condray, Senior Assistant
General Counsel, Legal Services
Corporation, 3333 K Street, NW.,
Washington, DC 20007–3522; (202) 295–
1624; mcondray@lsc.gov.

SUPPLEMENTARY INFORMATION:

Recipients

of Legal Services Corporation
("Corporation") funds are permitted by law to
provide legal assistance only to U.S. citizens
and certain legal aliens. Recipients are
required to verify the

Appendix D

Tests and Certificate

**Pre-test
Feeding Assistant Program**

Facility Name: _____

Student Name: _____

1. A feeding assistant is someone who:
 - a. is any individual who helps feed residents in nursing homes during mealtimes.
 - b. Is a certified nurse assistant who helps feed residents in nursing homes during mealtimes.
 - c. is any non-professional having completed a minimum of 8 hours of specific training that includes topics such as communication skills, infection control and emergency responses.
 - d. Is a nursing home employee such as the administrator, housekeeping, laundry workers and other non-professional who successfully completed 8 hours of specific training.
 - e. c and d.

2. Describe the distress signs of choking.
The universal sign of choking is _____. The choking victim is unable to _____ or _____ and there may be _____ on inhalation.

3. Which resident may a feeding assistant feed?
 - a. A resident with dementia
 - b. A resident with swallowing problems
 - c. A resident who has a tendency to aspirate or choke
 - d. A resident who receives IV feedings

4. The nurse asks you to give Mr. Conley his pills while you are feeding him. You should:
 - a. Place the pills in his mouth and give him a drink
 - b. Dissolve the pills in his coffee
 - c. Tell the nurse that you are not permitted to give medications
 - d. Put the pills in your pocket

5. A person with diabetes must avoid what kind of food?
 - a. Food with salt
 - b. Food high in sugar
 - c. Food with cholesterol
 - d. Dairy products

6. What happens to metabolism as we age?
 - a. It speeds up.
 - b. It slows down.
 - c. It stays the same.
 - d. No one knows.

7. How can a feeding assistant prevent a resident from becoming dehydrated?
 - a. Make sure they eat all of their food.
 - b. Check the diet card on the tray.
 - c. Encourage them to drink all of the fluid on the tray.
 - d. Think of interesting things to talk about during mealtime.

8. Which of the following is a sign of dehydration?
 - a. Refusal to eat.
 - b. Refusal to drink anything warm.
 - c. Dry or cracked lips.
 - d. Bright red rash.

9. There is an NPO sign on a resident's door. This means that:
 - a. The resident must be fed
 - b. The resident cannot have anything to eat or drink
 - c. The resident can only liquids
 - d. The resident cannot have visitors

10. Which of these resident behaviors should you report to the charge nurse?
 - a. Complaints that the food tastes funny
 - b. A sudden change in the amount of food a resident eats
 - c. Problems chewing
 - d. All of the above

11. Which of the following is NOT part of serving a resident's meal?
 - a. Opening condiment packages
 - b. Cutting meat into small pieces
 - c. Tasting to check the seasoning
 - d. Opening the milk carton

12. The Heimlich Maneuver is:
 - a. a German fire egress procedure.
 - b. a feeding technique.
 - c. done to clear the airway when a resident is choking.
 - d. All the above.

13. Food provides nutrients that are necessary for the body to function.
 - a. True
 - b. False

14. A poor dining atmosphere can result in:
 - a. arguments
 - b. a decreased appetite.
 - c. poor communication between residents.
 - d. an opportunity to discuss the mealtime with residents.

15. It is not necessary to report every difficulty with feeding a resident to the nurse.
 - a. True
 - b. False

Final Examination
Feeding Assistant Training

Facility: _____ **Date:** _____

Student Name: _____ **Score:** _____

1. Hand-washing is important because:
 - a. it spreads infection
 - b. it keeps your hands from getting dry skin.
 - c. it helps stop the spread of infectious organisms.
 - d. None of the above.
2. Hand-washing requires all the following except:
 - a. soap.
 - b. moisturizer
 - c. water
 - d. friction
3. The food pyramid is:
 - a. a specialized Egyptian architecture.
 - b. a way to describe servings of the basic food groups.
 - c. a way to eat properly prepared foods.
 - d. a dietitian's tool determining a resident's nutritional intake.
4. A 2-4 gram sodium diet has the following restrictions:
 - a. Sweets
 - b. Electrolytes
 - c. Protein
 - d. Salt
5. Ten (10) ounces of fluids equals 300 ccs
 - a. True
 - b. False
6. The universal sign of choking is _____. The victim is unable to _____ or to _____.
7. When feeding a resident who has had a stroke and is weak or paralyzed on the left side, which side should you position yourself to feed them? _____.
8. The nurse asks you to give Mr. Johnson his pills while you are feeding him. You should:
 - a. Place the pills in his mouth and give him a drink
 - b. Dissolve the pills in his coffee
 - c. Tell the nurse that you are not permitted to give medications
 - d. Put the pills in your pocket
9. Which of the following is part of serving a resident's meal?
 - a. Feeling the food for temperature
 - b. Tasting to check the seasoning
 - c. Having a simple conversation with the resident you are feeding.
 - d. Pouring fluids gently into the resident's mouth and encouraging them to swallow.

10. What is dysphagia?
 - a. A chronic cough
 - b. Problems swallowing
 - c. A feeling that something is caught in the throat
 - d. Too much saliva
11. Which of the following are signs that a person might have dysphagia?
 - a. The resident needs to swallow 3 or 4 times after each bite
 - b. Coughing before, during, or after swallowing
 - c. Drooling
 - d. All the above
12. What is the first step for a feeding assistant?
 - a. Taking the resident to the dining room
 - b. Getting the resident's menu
 - c. Preparing the resident's tray
 - d. Washing hands thoroughly
13. When is it necessary to force the resident to eat?
 - a. When the person has lost weight.
 - b. When the person is always a problem eater.
 - c. When you have tried everything you know.
 - d. You should never force a resident to eat.
14. Which behavior is never appropriate for a feeding assistant?
 - a. Encouraging them to eat more of a food.
 - b. Using a plastic spoon.
 - c. Talking to another person while feeding a resident
 - d. Asking them to use a straw for drinking fluids.
15. Which of the following is not helpful for a resident who wanders away from the table?
 - a. Use a waist belt and tie the resident in a chair
 - b. Offer finger foods that the resident can eat while walking
 - c. Provide between meal snacks
 - d. Have food ready when the resident arrives for the meal
16. Mr. Johns always eats with his hands. What would be helpful?
 - a. Tap his hand and say, "Don't do that, Mr. Johns".
 - b. Provide finger food
 - c. Don't give him liquids
 - d. Hold his hands
17. When communicating with someone who is hearing impaired always:
 - a. Make sure the resident sees you.
 - b. Touch them gently to indicate you want to speak to them.
 - c. Remember that residents hear even more poorly when they are ill or tired.
 - d. a & c
 - e. All the above

18. Name 3 forms of non-verbal communication.
- a. _____
 - b. _____
 - c. _____
19. Name 3 of the 6 things microorganisms need to grow.
- a. _____
 - b. _____
 - c. _____
20. Time and temperature are 1 of the 3 causes of food-borne illness. What is 1 of the other 2?
- a. Not cleaning cooking ware.
 - b. Cross contamination
 - c. Inadequate storage of foods
 - d. Poor personal hygiene
21. Maryland allows feeding assistants to feed residents in their room when it is the resident's choice.
- a. True
 - b. False
22. The first action of the feeding assistant when someone grabs his or her throat is:
- a. 3 quick slaps on the back
 - b. Lay them on their back on the floor
 - c. Ask them if they are choking
 - d. Instruct them to take a deep breath.
23. It is not necessary to notify the charge nurse in a successful use of the Heimlich maneuver.
- a. True
 - b. False
24. The facility Administrator is not required to complete the feeding assistant training because they are knowledgeable of the proper techniques.
- a. True
 - b. False
25. The feeding assistant is considered a part of the facility staff for licensed and unlicensed staff purposes.
- a. True
 - b. False

Test Keys

Pre-test Key

1. e
2. the hands to the throat; speak; breathe; high pitched noises on inhalation
3. a.
4. c
5. b
6. b
7. c
8. c
9. b
10. d
11. c
12. c
13. a
14. b
15. b

Test Keys

Final Exam Key

1. c
2. b
3. b
4. d
5. a
6. Hands to throat; speak; breathe
7. on right side or unaffected side
8. c
9. c
10. b
11. d
12. d
13. d
14. c
15. a
16. b
17. e
18. Posture; Gestures; Eye contact; Body movement; Appearance; Facial expression
19. FATTOM, Food; Acidity; Temperature; Time; Oxygen; Moisture
20. b or d
21. b False
22. c
23. b False
24. b False
25. b False

Certificate of Achievement



This certificate is presented to

who has completed the Eight Hour

Feeding Assistant Training

Signature of

Trainer:

Date

OHCQ APPROVAL
HFAM: Partners in Quality Care

From: Lynne Condon
Sent: Wednesday, October 15, 2003 3:56 PM
To: gnikstaitis@hfam.org
Subject: Feeding Assistants

Dear Nik,

I have reviewed HFAM's curriculum for Feeding Assistants, and found that it covers all the required elements as outlined in the Federal Register.

Any facility that wishes to use this program will need to let me know that this is the curriculum that they are using and it will be noted in their file. If they choose to alter or customize this program in any way they will need to submit the revised curriculum to OHCQ.

Please remember surveyors will sometimes ask to see which training program a facility is using. The facility will need to be able to provide the surveyor with access to the curriculum taught and test scores for the new Feeding Assistant(s).

Lynne

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| Electronic signature verified at 4PM 10-15-2003 GN |
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